goodwindental

Photo Release

I hereby authorize Dr Goodwin or his assistants to take photographs and/or videos of my face, jaws, mouth, and teeth.

I understand that the photographs and/or videos will be used to better communicate my care, for educational purposes in study club meetings, lectures, seminars, and professional publications.

I further understand that if the photographs or videos are used in any publication my name or other identifying information will be kept confidential.

I do not expect compensation or financial reward for the use of these photographs/video and release Dr Goodwin and any member of his team from legal or equitable claims in the use of photos for purposes stated above.

Signature _____

Date _____