PATIENT CONSENT

To be completed by patient
(Or, parent/guardian, if patient is a minor)

Patient name: ______________________________________ Date: _____________
Please Print

I hereby confirm that I give consent for the photographs (Photos) made of me by Dr. Margareta M. Gavrila.

I understand the Photos have educational value. I consent to the Photos and/or reproductions being shown to appropriate professional staff and used in educational publications, journals and textbooks and may be reproduced in any other form or medium including electronic publication or distribution anywhere in the world. As a result, I understand that the general public may see the Photos. All or part of the Photos may be used in conjunction with other photographs, drawing, videotape images, sound recording or other forms of illustration. Efforts will be made to conceal my identity, but full confidentiality is not guaranteed.

I may view the Photos by arrangement with Dr. Margareta M. Gavrila. However, once released I realize that recovery of the photographs may not be possible. I understand that no fee is payable to me for the Photos by Dr. Margareta M. Gavrila or any other person either now or at any time in the future.

I confirm that the purpose for which the Photos may be used has been explained to me in terms that I understand.

Also, I understand that refusal to consent will in no way affect my dental care.

Please check one box only.

☐ **I agree** with the above patient statement: ______________________________
Signature (patient or parent/guardian)

☐ **I disagree** with the above patient statement; I do not want my Photos used for publication; I only consent for the Photos to be used for the purpose(s) I have indicated below:

- Use for confidential dental records...Yes or No (Circle one)
- Use for teaching...Yes or No (Circle one)

____
Signature (parent/guardian)