# POLLES CENTER FOR DENTISTRY
## Photography Release

**I, _____, hereby authorize Dr. Polles and/or associates or staff members to take photographs, slides, and/or videos of my face, jaws and teeth.**

**I understand that the photographs, slides, and/or videos will be used for educational purposes in lectures, demonstrations, advertising (including website publication) and professional publications (dental magazines and journals).**

**I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.**

_____ _____

**Patient's Signature** **Date**