PHOTO RELEASE

I, _____, hereby authorize Dr. Kerri Hill to take photographs of my face and teeth for records.

Social Media

I understand that Dr. Kerri Hill may choose to display images that include before, during and after my procedure across multiple social media platforms like Instagram, Facebook, Snapchat, etc.

I allow Dr. Kerri Hill to use photographs with my:

Face _____
Mouth _____
Both _____

I allow Dr. Kerri Hill to tag me on Instagram
@_____

I do not allow Dr. Kerri Hill to use my photographs _____

Publication (digital & print)

Cases chosen to be discussed in articles and medical journals include images of patient's smile/teeth and may include full face images.

I allow Dr. Hill to use my case for publication
I do not allow Dr. Hill to use my case for publication

I do not expect compensation, financial, or otherwise, for the use of these photographs. I agree that Dr. Keri Hill/The art of dental wellness will not be liable for any claims, demands, actions, or causes of action or any sort whatsoever resulting from the publication of these photographs. I hereby forever release and discharge Dr. Kerri Hill/The art of dental wellness from all such claims, demands, actions, or causes of action.

Patient name (print) **Signature** **Date**