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DFWSmiles.com

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Photo Release Form

I, ____________________________, agree to allow DFW Smiles to capture, edit and publish my before and after treatment images. I understand that this may include, but is not limited to, publication in local media, use in electronic and print marketing/promotion and inclusion on the official DFW Smiles website and social media outlets. I also agree to submit a written request to DFW Smiles if/when I wish my photo(s) be removed from the website and/or marketing or promotional materials.

____
Patient's printed name

____
Guardian's printed name (if patient is a minor)

Patient/Guardian Signature: ____

Date: ___________________