Photo Release Form

I have consented to have photographs taken. I understand they may be used for documentation and for illustration of my treatment. In addition, they may be used (without name) to illustrate a particular procedure or technique to other patients within the office and on the website.

Patient Name: _____

Patient Signature: _____

Date: _____

Witness Name: _____

Witness Signature: _____

Date: _____

5920 W William Cannon Building #6 Suite #200, Austin, TX 78749
(512) 892-2273
www.hedgecockdental.com