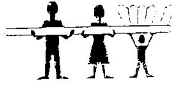

KELVIN B. SMITH, D.D.S., LLC
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(410) 277-9206
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Patient Photo Release Form

I ______________________________________, hereby authorize
(Print)

Dr. Kelvin Smith and Associates or any of their assignees to take photographs, slides ad or videos of my jaws, teeth and internal views.

I understand that the photographs, slides and/or videos will be used as a record of my care only. They will not be used for educational purposes.

Signed___________________________________ Date____________
Signature of Patient, Parent or Guardian

____ Date__________
Patient name if Under Age 18