Bruce G. Freund, D.D.S., LLC

700 E. Palisade Avenue, Englewood Cliffs, NJ 07632

CONSENT TO DENTAL PHOTOGRAPHY

I, ________________________________ , authorize Bruce G. Freund, D.D.S., to take photographs, and/or videos of my face, jaws, teeth and throat, before, during and after treatment.

I consent to allow the photographs to be used for the following:

• Dental Records

• Dental Research

• Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books

• Marketing material, including websites and printed materials, patient education

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

___ Check here if you do not want your full face shot used for any of the above purposes

Signature ________________________________ Date ___________