

Tam T. Le, DMD
Photographic Consent Form

Patient Name: _____

Date of Birth: _____

I hereby acknowledge that photographic documentation of pertinent facial areas is a routine practice of Dr. Tam Le as a General Dentist. I therefore give my consent to allow photographic documentation and understand that all identifiable characteristics will be protected and conform to patient privacy policy.

I further grant permission for the use of any of my dental records, illustrations, photographs or other imaging records created in my case for purposes of patient education, scientific presentations and publications. The exceptions are:

_____.

I also understand that there is no financial compensation rendered for consent of use, but that it will contribute to the understanding and advancement within the field of Dentistry.

Patient's/ Guardian's Signature

Date