CONSENT TO USE PHOTOGRAPHS

By my signature below, I hereby give my consent for Dr.Shalini Thasma D.D.S., to take photographs of me for use in medical or dental teaching and writing.

These photographs may be published in medical books, journals or CD-ROMS or displayed on medical or dental Internet sites or in the office website www.myplanodental.com to advance medical knowledge, practice or education. These photographs may also be used for advertising in social media like Facebook, Instagram etc.

I am over 18 years of age.

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(Patient Signature)

____

(Print Name)

(Date)

CONSENT OF PARENT / GUARDIAN TO USE PHOTOGRAPH OF CHILDREN

(To be obtained when subject is under 18 years of age)

I am the parent/guardian of ________________________________, and by my signature below, I hereby give my consent to Shalini Thasma, D.D.S., to take photographs of him/her for use in medical or dental teaching and writing. These photographs may be published in medical books, journals or CD-ROMS or displayed on medical or dental Internet sites to advance medical knowledge, practice or education.

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(Patient Signature)

(Date)