



Photographic Model Release

Date: _____

Patient's Name (Please print): _____

I hereby give Kellogg and Latz Dentistry the permission to use my study models, radiographs, and/or photographs in publications, on the website/social media, and/or in lecture presentations.

I release and discharge Kellogg and Latz Dentistry from any and all claims, actions and demands arising out of or in connection with the use of said study models, radiographs, and/or photographs.

I represent that I am over the age of eighteen years and that I have read and completely understand the contents hereof.

Signature of patient (or guardian if patient is under 18 years of age):

Witnessed by (Please print): _____

Signature of Witness: _____

