Dr. Surat Attaphitaya, DMD, MS
Specializing in Orthodontics for Children and adults

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Photography Consent

I, _____,

hereby authorize Dr. _____ or his assistants to take photographs, slides, and/or videos of my face, jaws, mouth, and teeth.

I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes.

I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential.

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

Signature _____

Date _____