Lakefront Family Dentistry and/or Derek B. Hauser, DDS

Photograph Authorization

I hereby give my consent for Dr. Hauser and Lakefront Family Dentistry to take photographs, slides and/or videotape of _____ (patient's name). I also grant permission to reproduce, print and/or publish these images for use in articles, lectures, or advertisements to promote our practice.

I understand that some of these images may be used on our company website and/or our company Facebook page.

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

Please initial below:

_____ I consent to the use of my photographs, slides, and/or videotape for articles, lectures, marketing, and advertising.

I understand that the information disclosed under this authorization may be subject to redisclosure and no longer protected by the federal privacy regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. Finally, I understand that I may revoke this authorization in writing at any time by sending a letter to my dental care provider stating my revocation and the effective date, except to the extent that action has been taken in reliance on this authorization. Unless revoked by me, this authorization expires 10 years from the date I sign below.

_____ _____

Patient's or Legal Guardian's/Representative's Signature Date

_____ _____

Dentist's Signature Date

_____ I DO NOT AUTHORIZE MY CONSENT

PLACE A COPY IN THE PATIENT'S CHART