Authorization for Photography

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IMPLANT, ESTHETIC, & RECONSTRUCTIVE DENTISTRY

Clinical photography is an extremely important facet of treatment. In our practice at SRK, we use photography frequently to enhance the outcome of your clinical treatment.

New patients contemplating prosthodontic treatment in our office will benefit from a comprehensive evaluation. In addition to appropriate history taking, data collection, radiographs, study casts, and clinical evaluations, diagnostic photography is sometimes essential for proper evaluation and treatment. It documents pre-operative conditions for your permanent record as well as allowing us to review your dental condition without you having to be here! **In fact, we often find it below the current standard of care (if not impossible) to completely evaluate, diagnose and treatment plan your dentistry without photographs**.

During your new patient evaluation, a standard series of photographs may be made. These will be placed in your permanent record as a digital image and are available to you at any time. We may also share these images with any dentist or physician that is on your treatment team to better communicate and treat your condition.

During treatment, photographs may be taken to document certain intra-operative conditions. These too may be shared with the treating doctors to help better your outcome. Post-operative photographs may be taken to document outcome for your record. They may be displayed on our website or social media, or to other patients in the office who are would benefit from seeing the results achieved. These are also commonly shared with your referring doctor, and may be shown to other doctors as examples of the great results we can achieve.

YOUR PRIVACY IS OUR COMMITMENT. THE IMAGES ARE OF YOUR TEETH AND IN ACCORDANCE WITH HIPAA LAWS, AT NO TIME ARE ANY IDENTIFYING FEATURES SHARED WITH ANYONE ASIDE FROM YOUR TREATING DOCTORS.

I ACKNOWLEDGE RECEIPT OF THIS AUTHORIZATION FOR PHOTOGRAPHY AND ALLOW FOR PHOTOS TO BE TAKEN, AS DESCRIBED.

PATIENT NAME: _____

PATIENT SIGNATURE: _____ DATE: ____ / ____ / ____