Lake Travis Oral and Maxillofacial Surgery, PLLC.

Consent and Release for Photographs, Videotapes, and Digital Recordings

This is a consent that has been prepared to help inform you concerning permission to take photographs, slides and/or videotapes and to use these images for a purpose as defined within this consent document.

I authorize Dr. Jeff Alford and his employees, or associates to take photographs, videotape or digital recordings of me in print and electronic media for the purpose of medical and dental education or publication

I understand I will not be entitled to monetary payment or any other consideration as a result of the use of these images. I understand my name will not be used.

Please initial:

_____Accept OR ____Decline

Name: _____ Date:_____

Signature:_____

If not the patient, Relationship to the patient:_____

Representative of Lake Travis Oral and Maxillofacial Surgery_____