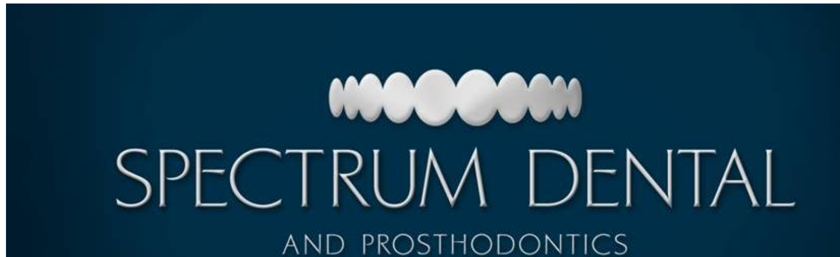

Dr. Bradley Purcell Dr. Kim Laurell Dr. Ryan Mizumoto

I, ____
First Name **Last Name** **DOB**

consent to medical images and /or video being made of me or my child / dependant. I agree that duplicates may be made for the referring doctor.

I agree that the images may be:	**Yes**	**No**
Used for education and training	☐	☐
Can use face images	☐	☐
Can use mouth images only (base of nose to chin)	☐	☐
Used on office website (Spectrum-dental.com)	☐	☐
Can use face images	☐	☐
Can use mouth images only (base of nose to chin)	☐	☐
Used on office You tube site (Spectrum Dental)	☐	☐
Can use face images	☐	☐
Can use mouth images only (base of nose to chin)	☐	☐

By signing below, I confirm that I understand this consent form.

____ __________
Signature of Patient/Parent or Guardian Date

____ __________
Signature of Doctor/Staff Date

55 Caren Avenue
Suite 270
Worthington, OH 43085

phone 614-885-7721
fax 614-888-0284
www.spectrum-dental.com