



Photo Release Form

I, _____ give permission to Kuhnel Dentistry, PA to
PRINT NAME

Use my:

- Full Face photos only
 Teeth photos only
 All of the above

For:

- In-office use only
 Print only
 Internet only
 All of the above

Share X-rays and/or necessary photos with other dental professionals as needed
(example: email X-rays to a specialist for Root Canal or Extraction)

I would be willing to give a video testimonial

I would be willing to give a written testimonial

Kuhnel Dentistry greatly appreciates your permission to show off your beautiful teeth!

Thank you!!

PATIENT SIGNATURE

DATE