Photography Release Form

I, the undersigned, authorize Southmoor Pediatric Dentistry, P.C. to submit the publication photograph(s) of me or my child.

(Name(s) of photographed individual)

_____

This is my consent for the photograph(s) to be displayed within our office, Southmoor Pediatric Dentistry, P.C. for internal uses only.

_____ Date:_____