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PHOTOGRAPHIC CONSENT FORM - GENERAL RELEASE

I consent for dental photographs to be made of me or my dependent (or person for whom I am legal guardian). I understand that these photographs may be used in my dental record, for purposes of dental training, promotional purposes, or for publication in dental textbooks or journals. By consenting to these dental images, I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the dental care I will receive. If I have any questions or wish to withdraw my consent in the future, I may contact any representative of this office.

By signing this form below, I confirm that this consent form has been explained to me in terms I understand.

I consent for these photographs to be used in dental publications, including medical journals, textbooks, and electronic publications. I understand that the images may be seen by members of the general public, in addition to dental researchers and scientists that regularly use these publications in their professional education. Although these photographs will be used without any identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes and to be used for my dental record.

My signature below indicates that the information in this consent form has been explained to me, and I assent to the use of my images as outlined above.

Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____
Or Guardian