Photography Consent Form

I authorize Dr. Denise Cohen/Dr. Denise Cohen-Kronfeld, D.M.D., PLLC, to take photographs of myself and/or my child. I understand that the photographs may be used as a record of my child's care, and may be used for educational purposes in lectures, demonstrations to other patients, and professional publications. Further, these photos may be used in marketing efforts to include publications, websites, Facebook, Instagram, and other social media outlets.

I further understand that neither myself nor my child will receive any sort of compensation for the use of these photos.

_____ _____

Parent's Full Name Child's Full Name

_____ _____

Parent's Signature Date

Authorization to Use Testimonial Remarks

I authorize Dr. Denise Cohen/Dr. Denise Cohen-Kronfeld, D.M.D., PLLC, to use the testimonial remarks that I have provided for use in publications, websites, and social media outlets (such as Facebook and Instagram, among others) or as part of demonstrations, marketing efforts, or lectures.

I further authorize the use of my first name and my last name initial, as well as the town in which I live (e.g. Jane D., Woodmere, NY) to identify me as the source of this testimonial. If I include my child's first name in the testimonial, I authorize the use of my child's first name for the purpose of directly quoting the testimonial which I have written.

_____ _____

Parent's Full Name Child's Full Name

_____ _____

Parent's Signature Date