FAMILY DENTISTRY – IGOR KAMPFER, DDS, LLC
8800 LOCKWOOD, SKOKIE, IL 60077

Permission to take Photographs and Digital Images (X–Rays)

Patient Name (please print) _____ DOB ___/___/_____

I do hereby authorize Dr. Igor Kampfer and his staff to take impressions of my upper and lower teeth, photographs and digital images (X-Rays) of my face, jaws, and the hard and soft tissues of my mouth.

I understand that these orthodontic records, including models, photographs and digital images (X-Rays) may be used for promotional and educational purposes in lectures, demonstrations, and professional publications, and I hereby authorize said use.

I understand that educational uses may include presentations to other dental professionals or for use with other patients as part of their treatment planning. Promotional purposes may include use on Dr. Kampfer's Web-site, display in his office and in PowerPoint presentations to other patients.

All above named uses of orthodontic records will be in accordance with HIPPA rrgulations.

_____	_____	_____
Patient, Parent or Guardian Name	Signature	Date

_____	_____
Witness' Signature	Doctor's Signature