

ANNE ARUNDEL COMMUNITY COLLEGE

School of Health Sciences - Dental Hygiene Clinic

Health and Life Sciences Building (HLSB), Room 137

101 College Parkway, Arnold, MD 21012

Phone: 410-777-7213

PHOTOGRAPHY / VIDEO CONSENT FOR EDUCATION & MARKETING

Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____

Section 1 – Purpose

The AACC Dental Hygiene Clinic occasionally captures photographs, video recordings, or other digital images for educational, training, documentation, or promotional purposes. This form documents your permission or refusal to allow the use of your image or likeness.

Section 2 – Authorization Options (Please check the appropriate box.)

- Educational Use (Internal) – I consent to the use of my photograph, video, or image for classroom, instructional, clinical, or accreditation purposes. This includes faculty training, student presentations, simulation, or internal reports.
- Marketing / Public Use (External) – I consent to the use of my photograph, video, or image for public-facing materials, including AACC brochures, social media, websites, newsletters, and community presentations. I understand that once released publicly, these materials may be viewed or shared outside AACC’s control.
- No Consent – I do not authorize the use of my photograph, video, or image for any purpose. I understand that this choice will not affect my eligibility for care.

Section 3 – Acknowledgment

- I understand that participation is voluntary and will not affect my access to care or educational services.
- I understand that no payment or compensation will be provided for the use of my image or recordings.
- I understand that AACC retains ownership of all photographs, videos, and recordings taken by its authorized representatives.
- I may revoke this consent at any time in writing, but revocation will not apply to images already in use.
- I understand that any use of my image will comply with AACC policies and applicable state and federal laws, and that identifying information will not be disclosed without separate written permission.

Section 4 – Consent & Signature

By signing below, I indicate my consent (or refusal) as selected above regarding the use of my image or likeness by AACC.

Patient / Legal Guardian Signature: _____ Date: _____

Printed Name (if guardian): _____

Relationship to Patient: _____

Section 5 – Clinic Use Only

Photo/Video Taken By: _____ Date Captured: _____

Purpose / Event: _____

Faculty / Staff Witness: _____ Date: _____

Notes: _____