

# Informed Consent

## Video Records

I understand that a video recording will be made of my treatment planning conference to serve as a documenting instrument and permanent record. I understand that this recording will be kept by my dentist in a confidential manner. I give my permission for this recording to be made.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Dr Byers \_\_\_\_\_ Date \_\_\_\_\_