**TUFTS UNIVERSITY SCHOOL OF DENTAL MEDICINE**

**Department of [XXX]**

**RECORDING AUTHORIZATION AND RELEASE**

*[Study Title]*

Principal Investigator: [Name, Credentials]

Study team telephone number: [###]

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand that video recording will be taken of [*describe procedures*]. I give permission to the researchers on this study to remove any individual identifiers from this recoding or other materials, such as my name, my medical record number, etc., and utilize these recording for analysis and in presentations and/or publications following my participation in this study. I am aware that the recordings will be reviewed by personnel outside of Tufts University.

I am aware that every effort will be made by the study team to not include my face in the video recording, but there is a chance that my face may be shown. I am aware that although personal identifiers will be removed, the video recording of my face, by nature, is still identifiable.

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Date Participant’s Signature