Photography Authorization & Release Consent Form

Materials
I hereby authorize Dr. [Dentist Name] or [his/her] assistants to photograph, videotape, audio record, broadcast, display and/or otherwise record my image, voice, likeness, name, verbal quotes, written statements, and story and information (the "Materials.")

Release of Information
I authorize use of this information regarding my dental health as part of the Materials. I understand that my private health information including diagnoses and treatment, will be part of the Materials. I also expressly consent to interviewing and recording my treating dental health care provider(s) regarding my dental health information and utilizing content from those interviews for the Materials. I understand that by releasing this dental information, it may no longer be covered by the Health Insurance Portability and Accountability Act's (HIPAA) protections from further disclosures.

Services from my dental providers are NOT conditioned on my signing and no services will be diminished or withheld if I do not sign below.

Expiration and Revocation
Dr. [Dentist Name] may use the Materials and the promotional items created using the Materials until they are obsolete or until I revoke this authorization and release. I may revoke this Authorization and Release by sending a written revocation to Dr. [Dentist Name] before production has begun on the promotional items created using the Materials. If I do revoke, it will not affect any Materials in production at the time of receipt of my revocation and will not be effective as to actions Dr. [Dentist Name] took relying on this Authorization and Release.

Compensation
I do not expect compensation, financial or otherwise, for the use of these photographs. I waive any right to royalties or other compensation arising or related to the use of the Materials.

I am at least 18 years of age and am competent to contract in my own name. I have read this Authorization and Release and I understand the contents, meaning, and impact of this document.

Signature of Patient Date

Print Name