PATIENT PHOTOGRAPH AND TESTIMONIAL AUTHORIZATION FORM

I herby give my consent for Showtime Orthodontic Arts, PLLC to take photographs, slides and/or videotape of (Print full name of patient) _____ face, jaw, and teeth. I understand that some of these images may be seen and used by other dental professionals, and these images will become part of the patient record.

If I have provided a written testimonial about my experience with Showtime Orthodontic Arts PLLC, I understand that my testimonial may be used in various media including, but not limited to practice website, brochures, and print advertising. Initial: _____

PLEASE CIRCLE "DO" OR "DO NOT" FOR EACH STATEMENT. AND INITIAL.

(I do, I do not) consent to feature these images in professional articles and presentations. Initial: _____

(I do, I do not) consent to feature these images within the dental practice to be seen only by individuals who walk into the practice. Initial: _____

(I do, I do not) consent to feature these images to promote the dental practice through various media, including but not limited to print advertising, brochures, and the practice website. Initial: _____

By consenting to the use of these photographs and testimonial as described above, I do not expect compensation, financial or otherwise, from and Showtime Orthodontic Arts, PLLC. I hereby release and Showtime Orthodontic Arts, PLLC from any and all claims and demands arising out of or in connection with the use of my name, photograph, personal testimonial, or other information provided by me, including any and all claims for libel and invasion of privacy.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits.

_____ _____

Print Patient's or Legal Guardian's /Representative's Name Date

_____ _____

Patient's or Legal Guardian's /Representative's Signature Date