PHOTO AND TESTIMONIAL RELEASE FORM

I, _____, hereby grant permission to Dr._____, to use my photograph and any testimonial I give regarding the dental care I receive from any such office, in any marketing, contests, advertising or teaching materials used to market or advertise his/her dental practices, including use on Dr. _____'s web site. I acknowledge Dr. _____'s right to crop or otherwise treat the photograph at his/her discretion. I also acknowledge that Dr. _____ may choose not to use my photograph and testimonial at this time, but may do so at his own discretion at a later date. I also understand that once my image is posted on Dr. _____'s web site, the image can be downloaded by any computer user, which is beyond the control of Dr. _____, and I will hold him/her and any of his affiliated offices harmless from any such use or download.

I hereby freely and voluntarily consent to the use of my photograph and testimonial as stated above until I revoke this consent in writing.

_____
Signature

_____
Printed Name

_____

_____
Address

_____
Date

_____
Parent/Guardian Signature (If under age of 18)

_____
Parent/Guardian Printed Name (If under age of 18)

_____

_____
Parent/Guardian Address (If under age of 18)

_____
Date

To revoke this consent in writing, please contact:

_____
Dr.

_____

_____

_____
(Business Address)