

## Patient Release Form

⇒ I am a patient of \_\_\_\_\_ (my dentist/lab technician). I understand that the purpose of this authorization is so that my dentist/lab technician may submit photographs, slides, video and similar materials (collectively, the "material") for the AACD's purposes, such as republication in AACD publications or related web sites. Notwithstanding the foregoing, I place the following additional limitations on this authorization:

⇒ \_\_\_\_\_. I understand that the material may identify me, and use my real name. I hereby authorize my dentist/lab technician and the AACD, its officers, agents, employees and affiliates, to use any or all of this material in AACD publications, advertisements, Web sites, exhibit booths, educational programs, social media, other media and other ways, such as reprints, which are deemed appropriate by AACD. This authorization shall apply to any successor or assignee of AACD.

I understand that while the AACD and its agents will attempt to provide high-quality reproduction of my photos, videos, the reproduction quality is not guaranteed. I understand that I will receive no compensation for use of the material. I will take no action against any party described in this authorization based on that party's use of the material unless such use or publication is malicious. I understand that use of the material will not include my full name and that the material may be used in individual or composite form. I understand that the material may be modified by AACD or its agents and I will not object to any such modification. I waive any right to inspect and/or approve the specific use of the material and/or associated text. My consent is freely and carefully given to the extent permitted under applicable law.

This authorization will expire ten years after the date I approve the authorization. I may revoke the authorization prior to that time period but any such revocation will not affect uses or disclosures of the material that have already occurred or have already been determined to occur in the future. For example, if the material is published in a brochure, the brochures created prior to the revocation or expiration will not be recalled and additional brochures may be created and the material used until the next overall update of the brochure. I can revoke this authorization by providing notice to my dentist/lab technician. I understand that information disclosed pursuant to the authorization may be subject to redisclosure by the recipient and may not be protected by applicable privacy laws.

I understand that my dentist/lab technician is not conditioning treatment or eligibility for benefits on whether I grant this authorization. I hereby release my dentist/lab technician and the AACD, its officers, agents, employees, and affiliates from any and all liability for using the material as described in this authorization. I may receive a copy of the signed authorization upon request.

⇒ \_\_\_\_\_  
Patients Signature Date

⇒ \_\_\_\_\_  
Print Patient's Name

If this authorization is signed by a personal representative of the patient (e.g., a parent of a young child) sign above as yourself and complete the following:

⇒ \_\_\_\_\_  
Personal Representatives Name Date

⇒ \_\_\_\_\_  
Relationship to Patient