HERRICKDENTAL

Photo/Video Release Form

I hereby give my consent Herrick Dental to photograph, film, videotape and then use, reproduce, and publish said images of me and/or my child/children.

_____

(Please print name)

_____

(Please print child's name, if applicable)

Authorization: I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by Herrick Dental, including but not limited to social media, practice website, direct mail, print advertising, digital advertising and other. I hereby release Herrick Dental from any and all claims whatsoever in connection with the use, reproduction, publication of the images thereof.

HIPPA: I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Purpose: The photographic/video images, and/or testimonial will be used for: Social Media and/or Advertising

Revocability: I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

No Treatment Conditions: I understand that the practice cannot condition treatment on whether or not I sign this authorization.

_____

Signature Date

_____

Signature for minor child

_____

Title/Organization

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