Smiles by Dr. Santos ®

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PHOTO AND TESTIMONIAL RELEASE FORM

I, _____, herby grant permission to Smiles By Dr. Santos to use my photographs and any testimony I give regarding the dental care I receive in any marketing, advertising, or teaching materials used to market or advertise this dental practice, including use on the Smiles By Dr. Santos website. I acknowledge Smiles By Dr. Santos's right to crop or otherwise treat the photograph at their discretion. I also acknowledge that Smiles By Dr. Santos may choose not to use my photograph and testimonial at this time, but may do so at their own discretion at a later time. I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, no other identifying information will be used unless stated differently. I do not expect compensation, financial or otherwise, for the use of these photographs.

I also understand that once my image is posted on Smiles By Dr. Santos's website, the image can be downloaded by any computer user, which is beyond the control of Smiles By Dr. Santos's control and I will not hold them and any of his affiliates harmless from any such use or download.

I acknowledge that to revoke the photo privileges, it must be completed in writing and sent to Smiles By Dr. Santos at 703 Mill Creek Rd, Suite H, Manahawkin, NJ 08050.

Please Initial

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

Exceptions:

_____ I do not wish to have my First Name shown or released.
_____ I do not wish to have my face shown.
_____ I only agree to have my teeth shown without any identifying features.
_____ I do not wish to have my photos used at all.

Patient/Guardian Name: _____ Date: _____

Patient/Guardian Signature: _____

Witness: _____