PATIENT PHOTOGRAPH AND TESTIMONIAL AUTHORIZATION FORM

I hereby give my consent for ***California Coast Dental Arts*** to take photographs, slides and/or recordings of *(Print full name of patient)* _____ . I understand that some of these images may be used by California Coast Dental Arts to promote the dental practice and/or be sent to laboratories for fabrication of crowns, veneers, bridges, or dentures and these images will become part of the patient record.

If I have provided a written or recorded testimonial about my experience with California Coast Dental Arts, the testimonial may be used in whole or in part as indicated below.

Please circle "do" or "do not" for each statement, and initial.

I do do not consent to the use of these images in professional articles and presentations. _____

I do do not consent to the use of these images within the dental practice to be seen only by individuals who walk into the practice. _____

I do do not consent to the use of these images to promote the dental practice through various media, including but not limited to print advertising, brochures, and the practice web site. _____

By consenting to the use of these photographs and testimonial as described above, I do not expect compensation, financial or otherwise, from California Coast Dental Arts. I hereby release and discharge California Coast Dental Arts 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

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

March 2013