AppleWhite Dental Illinois, P.C., dba

PHOTO / VIDEO RELEASE

MCLEAN COUNTY DENTAL
2103 E. Washington Street, Ste. 1C
Bloomington, IL 61701

The undersigned patient consents to be:

_____ Photographed _____ Videotaped _____Interviewed_______Other: ___________________________________

PERMISSION AND WAIVER:

I grant **McLean County Dental** its affiliates, its representatives and employees (the "Office") the right to take photographs or videos of me as indicated above ("Media"), to publish the Media and to identify me as a patient of the Office. I grant to the Office the worldwide, irrevocable and perpetual right and permission, in any media, known or hereafter known, to copyright, use and publish the same in print and/or electronically. I waive the right to inspect or approve prior to publication any Media. I understand the term "publish" as used herein encompasses publication, republication, distribution, reproduction, and any other transmission, in any media, whether currently known or unknown. I may inspect and copy any information used or disclosed under this authorization. I understand that a fee may be charged for such copying services.

USE OF MEDIA:

I understand that the Media will be used for the Office's publicity and advertising purposes. The Office will not sell the Media to any third party or otherwise receive compensation for the Media, otherwise than indirectly as a result of advertising and marketing efforts. I acknowledge that the Media will likely be disseminated to the general public at large, and that if the receiver of the Media is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

COPYRIGHT:

I agree that the Office may use the Media with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, video, social media and web content. I understand that the Office owns the copyright in all content it creates, including content that includes such photographs of me or my property [and my name]. To the extent that I possess any intellectual property rights, including, without limitation, rights of copyright, in the tangible media containing my likeness, I hereby assign all right, title and interest in and to such intellectual property rights to the Office. I understand that I am not entitled to any compensation in any manner as a result of any use of the Media.

RELEASE:

I release the Office from any claims or liabilities that may arise regarding the use of the photographs and/or video of me or my property [or my name], including any claims of defamation, invasion of privacy, or infringement of moral rights, rights of publicity, or copyright.

WARRANTY:

I represent and warrant that I am more than 18 years old and have the legal right to consent to and do consent to the terms and conditions of this Photo Release Form or, if the subject of the photographs is an individual under 18 years of age, that I am the parent or legal guardian of the individual being photographed, and I have read this Photo Release Form and approve of its terms.

REVOCATION:

This release is valid and effective until it is revoked by me. If not earlier revoked, this release will expire in 25 years. I understand that I may revoke this release at any time by notifying the Office in writing. The Office may rely on this release until it is revoked, and my revocation only extend to Media within the Office's control that have not been previously published.

NO CONDITIONS:

I am giving this release voluntarily. I understand that I may refuse to sign this authorization. The Office does not condition treatment, payment, benefit eligibility, or enrollment activities on the signing of this release. I will be provided a copy of this form upon request.

MY SIGNATURE BELOW ACKNOWLEDGES THAT I HAVE READ THIS RELEASE AND AGREE TO THE STATED ITEMS AS THEY HAVE BEEN OUTLINED. I HAVE BEEN GIVEN THE OPPORTUNITY TO HAVE MY QUESTIONS ANSWERED AND UNDERSTAND THAT I MAY MAKE INQUIRY TO THIS AGREEMENT AT ANY TIME. I FURTHER ACKNOWLEDGE THAT I MAY REVOKE MY CONSENT TO ALL OR ANY PART OF THIS CONSENT AGREEMENT AT ANY TIME BY DOING SO IN WRITING.

____ ____

PATIENT NAME (PRINTED) DATE

____ ____

SIGNATURE OF PATIENT/LEGAL RESPRESENTATIVE RELATIONSHIP TO PATIENT

SCAN TO PATIENT CHART / ORIGINAL TO PATIENT