PHOTO AND TESTIMONIAL RELEASE FORM

I, _____, hereby grant permission to [insert practice name] (referred to "The Practice" throughout the rest of this document) to use my photograph and any testimonial I give regarding the care I receive from any such office, in any marketing, contests, advertising or teaching materials used to market or advertise this practice, including use on our practice website.

I acknowledge the practice's right to crop or otherwise treat the photograph at his/her discretion. I also acknowledge that The Practice may choose not to use my photograph and testimonial at this time, but may do so at their own discretion at a later date. I also understand that once my image is posted on The Practice website, the image can be downloaded by any computer user, which is beyond the control of the practice and I will hold the practice and any of their affiliated offices harmless from any such use or download.

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

Specific Permissions: Image Use Preferences (Initial Next to Your Preference):

1) All images - no modifications requested _____

2) All images with identifying markers blurred/ blocked out _____

3) Images that I approve ONLY _____

4) I don't want any images of me used for marketing purposes. Images are only to record before and after results in MY patient file _____

_____ _____

Signature Patient or Guardian Signature *(If under age of 18)* **Date**

_____ _____

Signature Physician (Insert Physician Name) **Date**

***To revoke this consent in writing, please submit request in writing.*

Send to:

(Practice Name) (Practice Phone and Fax Number)

(Practice Address) (Practice Email)