Release Form for Media Usage

I, the undersigned, a Patient of Smile Academy Pediatric Dentistry (the "Practice"), do hereby acknowledge that the Practice has a legitimate interest in creating a photographic and/or audiovisual record of me, that the Practice desires to use such photographs and audiovisual recordings in various publications and promotional materials, including printed matter (i.e., flyers, brochures, newsletters, etc.), internet based information sites, DVDs, pod casts and other electronic media, and that my image and/or voice, may be the subject of and/or included in such photographs and/or audiovisual recordings by virtue of my participation in the Practice's promotional activities.

I, do hereby consent and agree that the Practice, its employees, or agents have the right to use photographs, videotape, or digital recordings of me and to use these in any and all forms of media and exclusively for the purpose of the Practice that has provided me with dental or orthodontic services. I further consent that my first name only may be used therein or by descriptive text or commentary.

Accordingly, I hereby grant to the Practice the right to photograph me and to record my image and/or voice by any means now known or herein after devised, in connection with the Practice's promotional activities, together with the perpetual but non-exclusive right to use, duplicate, and publish such photographs, and any such recordings of my image and/or voice, to edit and/or combine such photographs and recordings with other materials, music, and/or special effects, at the Practice's discretion, to identify me by first name only in connection with such photographs and/or recordings, or refrain from doing so, and to sell, license or otherwise distribute same for the purpose of promoting the Practice and its activities.

I hereby waive the opportunity or right to inspect or approve the proofs, negatives, tests, finished films, video, sound recordings and/or photographs or the uses to which the same may be put. All copies of my image and/or voice, created or recorded by the Practice hereunder shall be the sole and exclusive property of the Practice, including any and all prints and negatives depicting same. I waive any rights, claims, or interest I may have to control the use of my identity or likeness in whatever media used.

I hereby acknowledge that the copyright to any performance by me recorded by the Practice hereunder shall be owned exclusively by the Practice for the term of such copyright, all such rights in and to said performances having been transferred by me to the Practice hereby.

I represent that I have read and understand this agreement, and am competent to execute this agreement. No other Agreements currently exist which would prevent my transferring these rights to the Practice, or its successors and assigns. I acknowledge that the Practice intends to rely on this release, and the grant of rights herein contained, and shall incur significant costs in production of such photographs and recordings, and the materials and products containing same. As a result, I agree not to institute any legal action to contest the rights conveyed to the Practice herein. Further, I, for my successors and assigns, hereby release, and agree to indemnify and hold harmless, any and all employees, agents, affiliates, successors, assigns, contractors and/or vendors of the Practice, including those operating in a volunteer capacity, of and from any and all liability arising out the creation of such photographic images and/or audiovisual recordings, the publication, sale or other distribution of same or the exercise of the any other rights granted herein.

I have read and understand the contents of this release and am executing same of my own free will. If I am under 18 years of age, my parent and/or legal guardian _____ has signed below and by so signing acknowledges and agrees to the terms of this agreement, both individually, and on my behalf.

Patient:

Name (print): _____ Date: _____

Signature: _____

Parent and/or legal guardian (if Patient under 18)

Name (print): _____ Date: _____

Signature: _____