Patient Photograph, Video, and Testimonial Authorization

We would be honored to share your testimonial about our practice with other patients and possibly use them for marketing and advertising purposes. In order to do so we would like to obtain your authorization.

I hereby give my consent for Pediatric Dental Specialists to take photograph(s) and/or video(s) of _____.
Full name of child

If I have provided a testimonial about my experience with Pediatric Dental Specialists, the testimonial may be used in whole or in part as indicated below.

Please Initial:

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

By consenting to the use of these photographs and testimonial as described above, I do not expect compensation, financial or otherwise, at any time, from Pediatric Dental Specialists. I hereby release and discharge Pediatric Dental Specialists from any and all claims and demands arising out of or in connection with the use of my name, photograph, video, 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 sigh 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**

Pediatric Dental Specialists
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