PARKWOOD
DENTAL ASSOCIATES, P.A.

Photo/Digital Image Release & Ownership Consent

Name: _____

Location: _____

Subject: _____

I do hereby authorize Parkwood Dental Associates, PA, it's representatives and employees the right to take photographs of me and my property in connection with the above-identified subject. I authorize Parkwood Dental Associates, PA it's assigns and transferees to copyright, use and publish the same in print and/or electronically for general or educational purposes.

I agree that Parkwood Dental Associates, PA may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising and Web content.

I understand that there will be no compensation or additional consideration to me. I represent that I am of full legal age (or legal guardian of under aged patient) and competent to make this agreement. This consent will be in force for a term of ten years commencing on the date indicated below.

I have read and understand the above:

Patient Signature _____

Signature of Parent/Guardian (if under age 18):_____

Printed Name: _____

Organization Name (if applicable): _____

Date _____

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