Authorization:

By my signature below, I affirm, as a patient of the Practice named above OR as the parent or legal guardian of a minor child that is a patient of the Practice named above (I or my child, as the case may be, the "Patient"), that I authorize the Practice: (i) to capture photographic or video images of the Patient (the "Images"); (ii) to reproduce, use, and disclose the Images, with or without the Patient's name; (iii) to publicize the fact that medical services were provided to the Patient; and (iv) to reproduce and publish any testimonials the Patient provides regarding the Practice. All of the preceding information, including the Images, collectively is the "Information."

I further authorize the Practice to secure copyright registration for any materials that incorporate the Information, at the election and sole expense of the Practice. The authorization is given to the Practice listed above, for disclosures to any persons, without limitation, who may view the Information in printed or digital form in promotional materials including social media or Internet sites.

I understand that I may limit my authorization above in accordance with the Practice's policy pursuant to the Children's Online Privacy Protection Act, and that I may view a copy of that policy on the Practice's website located at: https://www.brighthealthysmiles.com/privacy-policy/.

Purpose:

The purpose of this authorization is to permit the Information, including Images, to be used for marketing of the Practice, and I explicitly consent to the use of Information for advertising and marketing activities to promote the Practice. I acknowledge and agree that no compensation will be provided for the use of the Information.

Expiration and Revocability:

This authorization expires when the Practice is informed that the Patient is no longer a patient of the Practice. I understand that I may revoke this authorization at any time by notifying the Practice by Certified Mail, return receipt requested. If I am signing on behalf of a minor child, this authorization may be revoked by the Patient when he or she reaches the age of majority.

In any case, I understand that protected health information already used or disclosed prior to any expiration or revocation may no longer be protected. Upon receipt of notice of expiration or revocation, the Practice will make reasonable efforts to remove protected health information from social media platforms over which it has control, but cannot guarantee removal from all Internet sites. I understand and explicitly acknowledge and agree that the Internet allows for wide sharing and forwarding of information, that the Practice cannot control all re-disclosure of information, and that the Patient will not seek to hold the Practice liable for the re-disclosure or continued public disclosure of information outside of the Practice's direct control.

No Effect on Treatment:

This authorization is voluntary. I understand that the Practice cannot condition treatment of the Patient on whether I sign this Authorization, and that my decision not to sign will not influence or affect the Patient's treatment in any way.