



Media Release Consent

I, _____, hereby consent to and authorize the use and reproduction of **Oral Surgery Specialists of Pueblo** and its affiliates, or anyone authorized by any of them, of any and all photographs, electronic images or video footage of me taken by any of them, or that they have in their possession, provided either by me or by a third party (collectively, the “Images”), as well as any of the digital files, proofs, and negatives connected and associated with the Images, for educational, commercial, or any other purposes without compensation to me. Such use shall include, but not be limited to, distributing the Images via print, visual and electronic media, specifically including any websites and social media sites such as YouTube and Facebook. I understand and agree that any Images authorized by me may also disclose my Protected Health Information (“PHI”) related to my treatment, condition, procedure, surgery or other PHI associated with such Images, and I specifically authorize this disclosure. The Images, as well as any of the digital files, proofs, and negatives connected and associated with the Images, shall be the sole property of the Practice and its Affiliates. The Practice and its Affiliates also shall have the right to use my name in connection therewith if they so choose.

I hereby waive any right to inspect or approve the finished product, photograph, video, DVD, CD-ROM or matter that may be used in conjunction therewith or to the eventual use that it might be applied.

I hereby release, discharge and agree to hold harmless the Practice and its Affiliates and their respective representatives, assigns, and employees, and any person acting under their permission or authority, from and against any claims whatsoever in connection with the use of my Images and name and the reproduction thereof as stated above, including any claim for payment in connection with the Images or distribution or publication thereof.

I understand that I have the right to refuse to sign this release and authorization and that it is strictly voluntary. If I do not sign this form, my dental health care and the payment for my dental health care will not be affected. I understand that this authorization will remain in effect until revoked by me in writing. I understand that I may revoke this authorization at any time in writing by delivering notice of revocation to the Practice, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. I understand that once the above information is disclosed, it may no longer be protected by privacy laws if such laws do not apply to the designated recipient, and it may be re-disclosed by the designated recipient. I understand that I may see and obtain a copy of the Images described on this form, for a reasonable copy fee, if I ask for it. I get a copy of this form after I sign.

IN WITNESS WHEREOF, I have duly executed the foregoing release and authorization on the date stated immediately below.

Signature of Patient / Legal Representative

Date

Witness

Date