



**PHOTO AND TESTIMONIAL RELEASE FORM**

I, \_\_\_\_\_, hereby grant permission to Daxon Dentistry to use all items checked below, regarding the dental care I receive from any such office, in any marketing, advertising or teaching materials used to market or advertise his/her dental practices, including use on Daxon Dentistry’s web site. I acknowledge Daxon Dentistry’s right to crop or otherwise treat the photograph at his/her discretion. I also acknowledge that Daxon Dentistry may choose not to use all items checked below at this time, but may do so at his/her own discretion at a later date. I also understand that once my image is posted on Daxon Dentistry’s web site, the image can be downloaded by any computer user, which is beyond the control of Daxon Dentistry, and I will hold him/her and any of their affiliated offices harmless from any such use or download.

I hereby freely and voluntarily consent to the use of following as stated above until I revoke this consent in writing. Please initial all items you consent to.

- |   |                                      |
|---|--------------------------------------|
| _____ - Use of Name (First Name and Last Initial) | _____ - Video                        |
| _____ - Use of Written Testimonial                | _____ - Oral Photos Before Treatment |
| _____ - Full Face Photo Before Treatment          | _____ - Oral Photos After treatment  |
| _____ - Full Face Photo After Treatment           | _____ - None                         |

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

To revoke this consent, please contact Daxon Dentistry.