For Dental Office Use:
This release is to be completed for each person recorded, photographed or captured on video. Store the signed form in the patient's records. If the subject is not a patient, forward the completed release to your Marketing Strategist with details about what event or media the release applies to. This release is valid for 10 years. Do not edit or alter this form in any manner.

For Support Office Use:
Save completed forms inside the office, event, or marketing folder it applies.

PARADISE DENTAL - Media Release Form

Use or Disclosure of Patient Photographic, Video and Testimonials Authorization Form

1. I authorize **[Paradise Dental]** located at **17840 Toledo Blade Blvd P.C. FL 33948** Paradise Dental to use and disclose for educational and/or marketing purposes my first name, photographic and/or video images of me, and/or testimonials that I have provided regarding the Practice (collectively referred to as "My Media"). I also authorize any vendor providing marketing services to the Practice, including Heartland Dental, LLC, to use My Media in marketing and educational materials/services for the Practice and for other dental offices. ***I understand that the use/disclosure (or redisclosure) of My Media means that it may no longer be protected by HIPAA privacy regulations***.

   The following are some of the types of locations in which My Media may be used:

   - Websites and other digital services
   - Social networking and social media platforms
   - Presentations to healthcare professionals, patients, stakeholders, and the general public
   - Brochures, direct mail, publications, and other marketing materials

2. The following personal details will not be disclosed:

   - My middle or last name
   - My address
   - My date of birth (age may be used ex. "37 years old")

3. I understand that My Media may be subject to redisclosure, including by third-party sites that may link to marketing materials without first having secured permission. I understand that the Practice and its vendors have no control over, and are not liable for, redisclosures.

4. I have a right to revoke this authorization by providing written notice to the Practice in person or by registered mail. Revocation affects future disclosures only and cannot apply retroactively to disclosures of My Media that have already occurred.

5. This authorization is voluntary, and I may refuse to sign it. Refusal to sign will not affect my eligibility for treatment, benefits or enrollment, or payment for or coverage of services.

6. This media release supersedes any previously signed media release and is valid for ten (10) years from the date signed.

7. I release the Practice and its third-party marketing vendors, including Heartland Dental, LLC, from any and all liability arising out of the use of My Media.

8. I understand that I have a right to (and will be given) a copy of this authorization after it is signed.

Patient Name (printed):_____ D/O/B:_____ Signature:_____ Date:_____

Witness Name (printed): _____ Signature:_____ Date:_____

Minors Only
If Patient is under the age of 18, then parent or legal guardian's consent is required.

I _____, parent or legal guardian consent to the foregoing. Signature: _____ Date: _____
Parent/Guardian Name (printed)

Copy was provided to Patient or Parent/Guardian by (name and title): _____