RELEASE AUTHORIZING USE OF PERSONAL LIKENESS (Photo Release)

I, _____ (patient name) consent to the use of my personal image and likeness, including but not limited to images representing and depicting the treatment provided to me and the effect thereof, by Whitney R. Mostafiz DMD MS P.C. for any lawful use she deems appropriate, including for treatment, advertising her services to the general public (including via social media and electronic media), illustration, and publication to the public at large for educational purposes.

I hereby relinquish any and all rights to my likeness or any image of me obtained by any photographic or digital means by Whitney R. Mostafiz DMD MS P.C. during the course of my treatment. I understand that I am entitled to no consideration, remuneration or payment for the use of my image in any advertising, promotional or educational materials.

I understand any image or likeness of me may be altered prior to use if deemed appropriate by Whitney R. Mostafiz DMD MS P.C.. I understand and agree that I have no right to be consulted about or approve of any such alterations before my image is used.

I understand that Whitney R. Mostafiz DMD MS P.C. will make all reasonable efforts to safeguard my privacy as required by applicable law, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand, however, that Whitney R. Mostafiz DMD MS P.C. cannot guarantee my complete privacy in the event my image or likeness is used by third parties.

I understand and agree that Whitney R. Mostafiz DMD MS P.C. may use information regarding my health condition, including information regarding my diagnosis, course of treatment, my date of birth and/or age and my other relevant medical conditions, in describing the treatment rendered to me as depicted in any image of me.

I understand that Whitney R. Mostafiz DMD MS P.C. may not and has not conditioned the rendition of treatment to me upon my authorization of the use of my image and/or likeness.

I have read the foregoing in its entirety and understand its terms.

_____
Patient name

_____
If patient is a ***minor***, guardian name and relationship to patient

_____ Provider signature

_____ Date

_____ Patient/guardian signature

_____ Date