Patient Photograph and Video Release

Patient's Name: _____ Patient ID: _____

Consent and Release

I hereby acknowledge that I have been advised that photographs and/or videos ("Content") will be taken of me or parts of my head, face, neck, and jaw before, during, and/or after certain dental procedures or treatment to document such procedures or treatment. This includes photos or videos taken prior to the date below. The Content will be taken on behalf or by one of the members of the Kona Smile Co ("KSC") staff and is the sole and exclusive property of KSC I hereby give my consent to KSC to use the Content for communication with other health care professionals, educational publications, educational lectures, patient and employee education, public education, marketing, promotions, advertising, posting on the KSC website, and posting on KSC social media accounts. In giving consent, I understand and agree that any Content authorized under this Agreement may include Protected Health Information under the Health Insurance Portability and Accountability Act ("HIPAA") related to my treatment, condition, procedure, or other service and may no longer be protected by HIPPA regulations.

I understand that:

- I will *not* be identified by name at any time unless I give consent to do so.
- Information shared with the public or posted on the Internet may be further shared by unrelated third parties for which KSC has no control.
- I may revoke this authorization in writing by contacting Kona Smile Co during normal business hours.
- Should I revoke this authorization, such revocation shall only be applicable to Content used after the date of revocation.
- No compensation, financial or otherwise, will be provided to me or my family.
- This authorization shall remain in effect from the date signed until the earlier of revocation or 12/31/2050.

I hereby release and discharge the photographer, KSC, its employees, officers, directors, agents, representatives, subsidiaries and affiliates, and all successors and assigns, from any and all claims, damages, actions and demands in any way arising out of or in connection with the use of the Content as authorized by this Agreement.

Patient or Legal Representative: _____Date: _____ Time:_____

Staff Member: _____ Date: _____Time: _____

If Legal Representative has signed on behalf of Patient, state authority of Legal Representative to do so:

_____

(i.e., parent, legal guardian, power of attorney, guardianship agreement)