Children's Dental Health of Lynchburg

Specializing in Children, Teens, and Young Adults

PHOTO AND TESTIMONIAL RELEASE FORM

I, _____, hereby grant permission to Children's Dental Health of Lynchburg to use my photograph and any testimonial I give regarding the dental care I receive in any marketing, advertising or, teaching materials used to market or advertise this dental practice, including use on Children's Dental Health of Lynchburg's web site. I acknowledge Children's Dental Health of Lynchburg's right to crop or otherwise treat the photograph at their discretion. I also acknowledge that Children's Dental Health of Lynchburg may choose not to use my photograph and testimonial at this time, but may do so at their own discretion at a later date. I further understand that if the photographs, slides, and / or videos are used in any publication or as a part of a demonstration, no other identifying information will be used unless stated differently. I do not expect compensation, financial or otherwise, for the use of these photographs.

I also understand that once my image is posted on Children's Dental Health of Lynchburg's web site, the image can be downloaded by any computer user, which is beyond the control of Children's Dental Health of Lynchburg and I will hold them and any of his affiliated offices harmless from any such use or download.

I acknowledge that to revoke the photo privileges, it must be completed in writing and sent to Children's Dental Health of Lynchburg at 7802 Timberlake Rd. Lynchburg, Va 24502.

Please Initial

_____I hereby freely and voluntarily consent to the use of my photograph and testimonial as stated above until I revoke this consent in writing.

Exceptions:

_____I do not wish to have my First Name shown, or released.

_____I do not wish to have my face shown.

_____I only agree to have my teeth shown without any identifying features.

_____I do not wish to have my photos used at all.

Patient/Guardian Signature _____

Patient/Guardian Printed Name_____

Date_____