BREATHE WELL SLEEP SOLUTIONS

PHOTOGRAPHY AND VIDEO RELEASE FORM

By signing this document, I authorize BREATHE WELL SLEEP SOLUTIONS, PLLC and authorized members to take photographs and/or videos of my child's face, mouth, teeth, and jaws, before, during and after treatment.

I understand that the photographs may be used for the following professional purposes:

- Dental Records
- Dental Research
- Dental Education, for myself and others, including but not limited to training purposes, lectures, presentations, etc.

I further understand that if the photographs and/or videos are used, my name and other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of my photographs and/or videos. I understand that the practice cannot condition the treatment I do or do not receive based on whether or not I sign this authorization. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Please check ONE of the following:

- ☐ "I consent to any of my child's photographs and/or videos being used in marketing material and advertisements, including but not limited use on social media, websites, printed materials, and in-office demonstrations."
- ☐ "I DO NOT consent to any of my child's photographs being used in marketing material and advertisements, including but not limited use on social media, websites, printed materials, and in-office demonstrations."

Date: _____

Patient's Name: _____

Parent or Legal Guardian's Name: _____

Parent or Legal Guardian's Signature: _____