American Academy of Cosmetic Dentistry®

Dentist / Lab Technician / Photographer/Videographer/Illustrator Consent to Release of Material

I am submitting photographs, slides and other materials (collectively, the "material") to the American Academy of Cosmetic Dentistry®, Inc. (the "AACD"). I hereby represent to the AACD that I have the authorization of the patient, _____ **[Insert patient name]**, to use the material and provide it to AACD for its uses, including but not limited to use in AACD publications, advertisements, web sites, exhibit booths, educational programs, social media, other media, and other ways such as reprints, that are deemed appropriate by AACD. If the patient revokes his or her authorization I will immediately provide written notice of the revocation to AACD. I hereby give my consent and permission to the AACD, its officers, agents, employees and affiliates, to use any or all of this material in such manner. I understand that I will receive no compensation for use of the material described in this consent. My consent is freely given to the extent permitted under applicable law. I hereby release and indemnify the AACD, its officers, agents, employees and affiliates from any and all liability for using the material as described in this consent. This release shall apply to any successor or assignee of AACD. I understand that the patient authorization provided by the AACD may not incorporate all applicable law and that I may contact my own legal counsel to review the authorization and this consent.

Photographer / Videographer/Illustrator Release (please check one of the following):
(1) If the dentist/lab technician is the photographer/videographer/illustrator;
(2) If another person (such as a professional photographer/videographer/illustrator) is the photographer /videographer/illustrator.
1.☐ I certify that I am the photographer/videographer/illustrator of the attached images taken of the patient or subject. I am the sole owner of all copyrights in said images, and own all right, title and interest thereto. (The default shall be this box if no box is checked).
2.☐Another person, identified below as the photographer/videographer/illustrator, is the photographer/videographer/illustrator and owner of all copyrights in said images and owns all right, title and interest thereto. I certify that I have obtained the photographer's signature, below, and agreement to this consent.

For good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the photographer/videographer/illustrator/s identified below or the dentist/lab technician hereby grants a non-exclusive perpetual worldwide royalty-free license to the AACD, an authorized agent of the AACD or any successor or assignee of AACD, to reproduce, publish, copy or prepare derivative works based upon the submitted images for the following purposes:

1. Print marketing, publicity or advertising campaigns promoting AACD, including use in brochures, advertisements, and informational literature;
2. Publication in dental journals in relation to articles about AACD or its members; via the AACD Web site, www.aacd.com.
3. Publication at trade shows through an AACD exhibit booth; and/or
4. Other purposes deemed appropriate by the AACD, including those described above.

There are no limitations on the type of media that may be used by AACD for the above purposes unless specified in writing on this form. All rights not expressly granted herein are retained by the photographer / videographer/illustrator.

_____ _____
Dentist and/or Laboratory Technician Signature Date

_____
Print Dentist and/or Laboratory Technician Name

Complete if dentist/laboratory technician is not the photographer/videographer/illustrator:

_____ _____
Photographer/Videographer/illustrator Signature Date

_____
Print Photographer/Videographer Name

402 West Wilson St.
Madison, WI 53703
PHONE 608.222.8583
800.543.9220
FAX 608.222.9540
WWW.AACD.COM

American Academy of Cosmetic Dentistry®

Patient Release Form

⇒ I am a patient of _____ (my dentist/lab technician). I understand that the purpose of this authorization is so that my dentist/lab technician may submit photographs, slides, video and similar materials (collectively, the "material") for the AACD's purposes, such as republication in AACD publications or related web sites. Notwithstanding the foregoing, I place the following additional limitations on this authorization:

⇒ _____. I understand that the material may identify me, and use my real name. I hereby authorize my dentist/lab technician and the AACD, its officers, agents, employees and affiliates, to use any or all of this material in AACD publications, advertisements, Web sites, exhibit booths, educational programs, social media, other media and other ways, such as reprints, which are deemed appropriate by AACD. This authorization shall apply to any successor or assignee of AACD.

I understand that while the AACD and its agents will attempt to provide high-quality reproduction of my photos, videos, the reproduction quality is not guaranteed. I understand that I will receive no compensation for use of the material. I will take no action against any party described in this authorization based on that party's use of the material unless such use or publication is malicious. I understand that use of the material will not include my full name and that the material may be used in individual or composite form. I understand that the material may be modified by AACD or its agents and I will not object to any such modification. I waive any right to inspect and/or approve the specific use of the material and/or associated text. My consent is freely and carefully given to the extent permitted under applicable law.

This authorization will expire ten years after the date I approve the authorization. I may revoke the authorization prior to that time period but any such revocation will not affect uses or disclosures of the material that have already occurred or have already been determined to occur in the future. For example, if the material is published in a brochure, the brochures created prior to the revocation or expiration will not be recalled and additional brochures may be created and the material used until the next overall update of the brochure. I can revoke this authorization by providing notice to my dentist/lab technician. I understand that information disclosed pursuant to the authorization may be subject to redisclosure by the recipient and may not be protected by applicable privacy laws.

I understand that my dentist/lab technician is not conditioning treatment or eligibility for benefits on whether I grant this authorization. I hereby release my dentist/lab technician and the AACD, its officers, agents, employees, and affiliates from any and all liability for using the material as described in this authorization. I may receive a copy of the signed authorization upon request.

⇒ _____ _____

Patients Signature Date

⇒ _____

Print Patient's Name

If this authorization is signed by a personal representative of the patient (e.g., a parent of a young child) sign above as yourself and complete the following:

⇒ _____ _____

Personal Representatives Name Date

⇒ _____

Relationship to Patient