TERSA
ORAL AND FACIAL SURGERY

Media Release Form

Date: _____

Patient Name: _____ **DOB**: _____

Consent and permission is granted to Tersa Oral and Facial Surgery, its affiliates, agents, employees, and to any person, firm or organization that this facility may designate or authorize to take photographs, pictures, or video/audio tape of me or my child/children. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

This consent includes the use of such photographs or films with or without the use of my name and biographical data concerning me or my child by Tersa Oral and Facial Surgery or anyone else on its behalf, without limitation as to time or frequency of use, modified or retouched, for any or all of the following purposes:

- ☐ Newspaper or web release
- ☐ Release to any other form of print or electronic media
- ☐ Educational, instructional or teaching purposes
- ☐ Research activities
- ☐ Publicity or fundraising

I expect no compensation or renumeration for the use of such photographs (still or motion picture) or for the use of my name and/or accompanying biographical data, and/or testimonial for marketing purposes by Oral Surgery and Implant Specialists and I specifically release Oral Surgery and Implant Specialists and all others from any liability or other obligation arising out of the use of the above material as I have herein authorized.

Revocability:

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

No Treatment Conditions:

I understand that the practice cannot condition treatment on whether or not I sign this authorization.

Do you give consent for media release? ☐ **Yes** ☐ **No**

Print Name of Patient/Guardian: _____

Signature of Patient/Guardian: _____