IMAGE CONSENT FORM

THIS FORM IS USED FOR THE FOLLOWING LOCATIONS:

NORTH RIDGEVILLE	NORTH ROYALTON	COLUMBUS
34155 CENTER RIDGE RD	12821 STATE RD	4589 KENNY RD
NORTH RIDGEVILLE, OHIO 44133	NORTH ROYALTON, OHIO	COLUMBUS, OHIO 43220

I, _____, ("Releasor") grant permission and consent to McCormack Dental Group, ("Releasee") for the use of the following photograph(s) of my face, jaws, and teeth, before, during and after treatment. I'm aware that these photos will be used for including but not limited to publicity, copyright purposes, illustration, advertising, and web content. I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs. Images will be stored in a secure location and only authorized staff will have access to them. They will be kept as long as they are relevant and after that time destroyed or archived. I understand that I may revoke this authorization at any time by notifying the McCormack Dental Group in writing. The revocation will not affect any actions taken before the receipt of this written notification.

_____ Initial here if you do not want your full face shot used for any of the above purposes.

We, the Releasor and Releasee, have understand and agree to the aforementioned terms and conditions.

Releasor's Signature: _____ Date _____

Print Name: _____

Releasee's Signature: _____ Date _____

Print Name: _____