Release Form For Social & Media Recording

I ____________________________________ DO
(Patient Name)

I______________________ ______________DO NOT
(Patient Name)

authorize the use and disclosure of my first name, photograph, video images, and/or testimonial for marketing purposes by Castle Peak Dental. The postings are for Facebook, Instagram, Twitter, our website and/or before and after photos to be displayed in our office. The posts will be used to promote office activities and celebrate achievements.

The Health Insurance Portability and Accountability Act still holds its place and no medical information will be release with the signing of this form.

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received in person. Revocation affects disclosure moving forward and is not retroactive. This authorization does not expire unless revocation is received in writing.

Signature: ____

Date: _______________________________________

Patients under the age of 18 years of age may not sign this without their parent present or parent's permission. If you are a parent signing for your child, please complete the following information.

If Patient is a Minor

Patient Name: ____

Parent/Legal Guardian: ____

Signature Parent/Legal Guardian: ____

Date: _______________________________________