PHOTO RELEASE

I _____ am a patient of Dr. Malki and understand that the purpose of this authorization is so that my dentist may submit photographs, video and similar materials (collectively, the "material") for purposes, such as publications or related web sites and social media. I understand that the material may identify me. I hereby authorize my dentist to use any or all of this material in publications, advertisements, web sites, exhibit booths, educational programs, other media and other ways deemed appropriate by Stephen J. Malki, D.M.D. This authorization shall apply to any successor or assignee of Stephen J. Malki, D.M.D. Notwithstanding the foregoing, I place the following additional limitations on this authorization: _____-_____.

I understand that while Stephen J. Malki, D.M.D will attempt to provide high-quality reproduction of my photos, 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 the party described in this authorization based on that party's use of the material unless such use or publication is malicious. I understand that the material may be used in individual or composite form. I understand that the material may be modified by Stephen J. Malki, D.M.D 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.

I may revoke the authorization at any time 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 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.

I understand that my dentist is not conditioning treatment or eligibility for benefits on whether I grant this authorization. I hereby release my dentist 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.

_____ _____

Signature of Patient (or parent if minor) *Date*

_____ _____

Print Patient's Name (or parent's if minor) *Relationship to Patient*