Korcek Dental

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PATIENT PHOTO & MEDIA RELEASE AUTHORIZATION

This authorization must be completed and signed before any images or recordings are used for any purpose.

1. PATIENT INFORMATION

Patient Full Legal Name ______________________ **Date of Birth** ______________

Address ______________________ **City** ____________ **State** ______ **ZIP** ______

Phone Number ____________ **Email Address** ______________ **Date of Treatment** ____________

If patient is a minor (under 18 years of age):

Parent / Legal Guardian Full Name ______________________ **Relationship to Patient** ______________ **Guardian Phone** ____________

2. GRANT OF AUTHORIZATION

I, the undersigned patient (or parent/legal guardian of the minor patient identified above), hereby voluntarily grant to **Korcek Dental**, its officers, employees, agents, contractors, and authorized representatives (collectively, "the Practice") the non-exclusive, royalty-free, perpetual, irrevocable, worldwide right and license to photograph, record, reproduce, edit, publish, display, distribute, and use my likeness, photographs, digital images, video recordings, audio recordings, and testimonials (collectively, "Images") in any and all media, formats, and channels now known or hereafter developed, including but not limited to:

- The Practice's official website (korcekdental.com) and any future Practice websites
- Social media platforms operated by the Practice, including Facebook and Instagram (@andrewkorcekdds)
- Printed marketing materials, including brochures, flyers, posters, and direct mail
- Digital advertising, including paid social media advertisements, display advertising, and email marketing
- Patient education materials, presentations, and professional conference materials

- Press releases, news articles, and media coverage
- Internal training and quality improvement materials

The Practice may use the Images individually or in combination with other images, text, graphics, or materials. The Images may be cropped, edited, color-corrected, or digitally altered at the Practice's discretion, provided such alterations do not materially misrepresent the patient's condition or treatment outcomes.

3. SCOPE OF IMAGES AUTHORIZED

Please initial next to each category of images you authorize. You may authorize all or only specific categories.

Initial	Category	Description
_______	**Intraoral Photographs**	Close-up photographs of teeth, gums, and oral structures before, during, and after dental treatment.
_______	**Extraoral / Smile Photographs**	Photographs of the face, smile, and surrounding facial features.
_______	**Full-Face Photographs**	Photographs that include the full face, including eyes and identifying features.
_______	**Before & After Images**	Side-by-side or comparative images showing dental conditions prior to and following treatment.
_______	**Video Recordings**	Video footage of the patient, treatment, or outcome, with or without audio.
_______	**Written Testimonial**	A written statement provided by the patient describing their experience or treatment outcome.
_______	**X-Rays & Radiographs**	Digital radiographic images, including panoramic X-rays, bitewings, and periapical images.
_______	**All of the Above**	Patient authorizes the Practice to use any and all image types listed above.

4. TREATMENT OR PROCEDURE DEPICTED

Describe the specific dental treatment or condition that is the subject of the Images authorized by this release:

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Date(s) of treatment depicted: ________________________________

5. HIPAA AUTHORIZATION & PROTECTED HEALTH INFORMATION

The Images authorized under this Release may constitute Protected Health Information (PHI) as defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164. By signing this Release, I expressly authorize Korcek Dental to use and disclose the Images for the marketing and promotional purposes described herein, which constitute uses beyond treatment, payment, and healthcare operations, and therefore require explicit patient authorization under 45 C.F.R. § 164.508.

I understand that once the Practice has used or disclosed the Images pursuant to this authorization, such use or disclosure may not be reversible. I understand that I have the right to revoke this authorization at any time by providing written notice to the Practice's Privacy Officer, except to the extent that the Practice has already relied upon this authorization.

I acknowledge that the Practice's treatment of me, or my eligibility for benefits, is **not conditioned** on whether I sign this authorization. Refusal to sign will not affect my access to treatment or any other healthcare services provided by the Practice.

6. PATIENT REPRESENTATIONS AND WARRANTIES

1. I am at least 18 years of age, or if a minor, the undersigned parent/legal guardian has full legal authority to execute this Release on behalf of the minor patient.

2. I have read and fully understand the terms of this Release and have had the opportunity to ask questions prior to signing.

3. I am signing this Release voluntarily, without coercion, and without any promise of compensation or special treatment.

4. I understand that no compensation, financial or otherwise, will be provided to me in exchange for this authorization unless a separate written compensation agreement has been executed.

5. I agree that the Practice shall own all right, title, and interest in and to any works incorporating the Images, including all copyright therein.

6. I release and forever discharge Korcek Dental, its officers, employees, agents, and assigns from any and all claims, damages, or liability arising from or related to the use of the Images as authorized herein, including any claim for invasion of privacy, defamation, or right of publicity.

7. RIGHT TO REVOKE

I understand that I may revoke this authorization at any time by submitting written notice to Korcek Dental at 1701 County Rd. Suite K, Minden, NV 89423, or by email to frontdesk@korcekdental.com. Revocation will be effective

upon the Practice's receipt of written notice. Revocation will not affect any use or disclosure of the Images that has already occurred in reliance on this authorization prior to the date of revocation. The Practice will make reasonable efforts to discontinue use of the Images upon receipt of a valid revocation.

8. SIGNATURES

Patient Signature ______________________________ **Date** ______________

Patient Printed Full Legal Name ______________________________

MINOR PATIENT AUTHORIZATION If the patient is under 18, this section must also be completed by the parent or legal guardian.

Parent / Legal Guardian Signature ______________________________ **Date** ______________

Parent / Legal Guardian Printed Name ______________________________

9. FOR OFFICE USE ONLY

Form Received By ______________ **Date Received** ______________ **Scanned to Chart? (Yes / No)** ______________

Notes: ______________________________