



## MAV DENTISTRY MEDIA RELEASE FORM

I, \_\_\_\_\_ (the undersigned), do hereby authorize and consent to Mav Dentistry and its representatives capturing, reproducing, and publishing photographs, X-rays, and video of me for marketing and educational purposes.

### SCOPE OF PERMISSION

I grant Mav Dentistry permission to use photographs, X-rays, or video recordings taken of me in professional publications, print materials, online platforms (including the Mav Dentistry website and social media channels), patient education resources, and in connection with lectures or presentations. This includes publication in the form of prints, film, or slides, in any format now known or later developed, exclusively for Mav Dentistry purposes.

### PRIVACY AND ANONYMITY

To protect my privacy, I understand and agree that my full name or any other personal identifying information will not be used in connection with these images unless expressly authorized in writing. No full-face or comparable identifying photos will be published without my specific, written consent.

### WAIVER OF PRIVACY CLAIMS

I specifically waive any claim for invasion of privacy related to the use of these images or recordings as permitted in this release. I understand and accept that my consent applies to the current and future use of these materials, within the stated purposes and scope.

### NO TREATMENT CONDITIONS

I understand that my decision to sign or not sign this authorization will have no impact on my treatment or the quality of care provided by Mav Dentistry.

### VOLUNTARY PARTICIPATION AND WAIVER OF COMPENSATION

I acknowledge that my participation in providing these images and recordings is entirely voluntary, and I will not receive any financial or other compensation for the use or publication of these materials. I understand and agree that Mav Dentistry retains full ownership rights to all captured images and recordings and that publication of these materials confers no rights of ownership, royalties, or other financial claims to me.

### ACKNOWLEDGEMENT AND SIGNATURE

I have read this release form fully, understand its contents, and voluntarily agree to its terms.  
(If under 18, this form must be signed by a parent or legal guardian)

Patient/Guardian Printed Name: \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Phone Number: \_\_\_\_\_