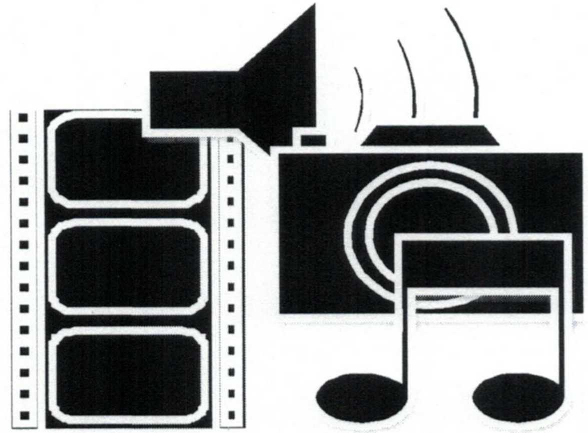
RELEASE FORM FOR MEDIA RECORDING For Adults



I, the undersigned, do hereby consent and agree that **SOUTH ARLINGTON DENTAL CARE,** its employees, or agents have the right to take photographs, videotape, or digital recording of me and use these in any and all media, including educational materials now or hereafter known, and exclusively for the purpose of such. I further consent that my name and identity may be revealed therein or by descriptive text or commentary, using this name I am providing ________________________________.

I do hereby release to **SOUTH ARLINGTON DENTAL CARE**, its agents, and employees all rights to exhibit this work in print and electronic form publicly or privately and to market and sell copies. I waive any rights, claims, or interest I may have to control the use of my identity or likeness in whatever media used.

I understand that there will be no financial or other remuneration for recording me, either for initial or subsequent transmission or playback.

I also understand that **SOUTH ARLINGTON DENTAL CARE** is not responsible for any expense or liability incurred as a result of my participation in this recording, including medical expenses due to any sickness or injury incurred as a result.

I represent that I am at least 18 years of age, have read and understand the foregoing statement, and am competent to execute this agreement.

Name: ____ Date: ________________________

Address: ____

Phone: ____

Witness for the undersigned: ____

Signature: ____