



Photograph Release

I hereby give Dr. Nikki Green, Bob Leedy and/or their staff permission to use my likeness in a photograph in any and all of its publications. I authorize Fort Worth Cosmetic and Family Dentistry to edit, alter, copy, exhibit, publish or distribute this photo for purpose of publicizing Fort Worth Cosmetic and Family Dentistry's programs or for any other lawful purpose.

I hereby forever release and discharge Dr. Nikki Green, Dr. Bob Leedy and any representatives, subsidiaries and affiliates, and all successors and assigns, from any and all claims, damages, actions and demands in any way arising out of or in connection with the use of such photograph, including but not limited to any claims for defamation or invasion of privacy. For a photograph of me, I represent and certify that (a) I am of legal age OR (b) for a photograph of a minor child, I represent and certify that I am the parent or the legal guardian of that child. Further, I represent and certify that I am not under any legal disability and that I have read the foregoing carefully and fully understand the contents and meaning of this release.

Print Name: _____

Signature: _____

Date: _____

Marketing Release

I would like Fort Worth Cosmetic and Family Dentistry to communicate with me via e-mail, phone, text, mail or other media about products or services that pertain to my conditions or that contribute to matters related to my health and/or my medical treatment. I understand my Protected Health Information may be referenced to determine that I may be likely a candidate for products or services that my dental health practitioner may share with me.

Fort Worth Cosmetic and Family Dentistry may communicate with me about my oral health, treatment, appointments, and post-operative follow-ups by mail, e-mail, text or by phone to the contact information on file. It is my responsibility to ensure all my contact information is up-to-date.

I understand that communication between Fort Worth Cosmetic and Family Dentistry and I may not be encrypted and my information could be intercepted by unauthorized persons.

Fort Worth Cosmetic and Family Dentistry will not be responsible for any unauthorized interceptions. However, we will make reasonable measures to ensure proper delivery or notification of our patient's information. [Examples include, but are not limited to, post-operative phone calls and appointment reminders.](#)

This consent remains in effect until expressly revoked (in writing).

Print Name: _____

Signature: _____

Date: _____

Witness: _____

Date: _____