***Media Release form***

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby give consent to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name of dental office), and all employees of Dentovations, Inc. the right to make any recordings of me in the form of photographs, video or audio. The recordings can be used presently and in the future with no purpose or time limitation. I further GIVE / DO NOT GIVE (Circle one) consent for my identity to be released in association with the recordings made of me. I release the right to exhibit the recordings to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of dental office) and all employees of Dentovations, Inc. for private or public use. I understand there will be no future compensation made to me for subsequent use of the material.

I have read and understand the content of this form.

Signature Date

Print name

Dental office name and address

**In-Office Use Only:**

* Using the recommended shade guide, what is the patient’s before and after shade?

Before Shade: After Shade:

* Is this the patient’s first time using uPhoria? Yes / No
* Upon completion, please email this form to: Dianaf@Dentovations.com