**Media Release Form**

I, , the undersigned, do hereby consent and agree that Brown Prosthodontics, its employees, or private contractors have the right to take photographs, videotape, or digital recordings of me throughout my dental care with Dr. Edward K. Brown Jr. I understand that this media will be used in any and all media, now or hereafter known, and exclusively for the purpose of Brown Prosthodontics. I further consent that my name and identity may be revealed therein or by descriptive text or commentary.

I do hereby release to Brown Prosthodontics, its private contractors, 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, featured articles or any promotion created with my media either for initial or subsequent transmission or playback.

I also understand that Brown Prosthodontics, Dr. Edward K. Brown Jr. 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.

**Authorization**

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and assign directly to Dr. Edward K. Brown Jr. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Edward K. Brown Jr. may use my health care information and may disclose such information to the insurance company listed above and their agents for the purpose of obtaining payment for services and determining insurance benefits for the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

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Signature of Patient, Parent, Guardian or Personal Representative Date

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Please print name of Patient, Parent, Guardian or Personal Representative Date

**Payment is due in full before the completion of treatment unless prior arrangements have been approved.**