



PATIENT AUTHORIZATION TO RELEASE OF MATERIAL FOR OFFICE USE

I understand that the purpose of this authorization is to give permission to Smiles by Mia to use photographs taken of me and my family, our story and similar materials (collectively, the "material") for the purpose of promoting the practice of Smiles by Mia. I hereby authorize Dr. Mia and any employees of Smiles by Mia to use any or all this material for any and all purposes, including without limitation: in AACD publications and advertisements; on web sites and exhibit booths; posting of social media and website; and in educational programs and related documentation and templates. This authorization shall apply to any successor or assignee of Smiles by Mia.

I understand that I will receive no compensation for use of the material. I will take no action against any party described in this authorization based on that party's use of the material unless such use or publication is malicious. I understand that the material may be modified by Smiles by Mia or its agents and I will not object to any such modification. I waive any right to inspect and/or approve the specific use of the material and/or associated text. My consent is freely and carefully given to the extent permitted under applicable law.

I understand that information disclosed pursuant to the authorization may be subject to redisclosure by the recipient and may not be protected by applicable privacy laws. I may receive a copy of the signed authorization upon request.

Patient's Signature: _____ Date: _____

Print Patient's Name: _____

If this authorization is signed by a personal representative of the patient (e.g., a guardian of a young child) sign above as yourself and complete the following:

Personal Representative's Name: _____

Relationship to the Patient: _____