

Give a Smile, Get a Camera Contest

PATIENT PHOTO RELEASE FORM

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____

Email Address _____

I hereby grant Bay View Dental Lab permission to use my likeness in a photograph in any and all of its publications, including website entries, without payment or any other consideration. I understand and agree that these materials will become the property of Bay View Dental Lab and will not be returned to me.

I hereby irrevocably authorize Bay View Dental Lab to edit, alter, copy, exhibit, publish, or distribute this photo for purposes of publicizing Bay View Dental Lab or any other lawful purpose. In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness appears. Additionally, I waive any right to royalties or compensation arising or related to the use of the photograph.

I hereby hold harmless and release and forever discharge Bay View Dental Lab from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf of my estate have or may have by reason of the authorization.

I am 18 years of age and am competent to contact in my own name. I have read this release before signing below and I fully understand the contents, meaning, and impact of this release.

Print Name _____ Date _____

Signature _____ Date _____



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