# Media Release Form

I, the undersigned, do hereby consent and agree that Don Roberts, DDS, LLC, its employees or private contractors have my permission to take photographs, videotape and/or digital recordings of me throughout my dental care with Dr. Don Roberts. I understand that this media may be used for patient education and/or marketing purposes by Don Roberts, DDS, LLC. I further understand that if used, my name and identity will remain anonymous.*

I do hereby release to Don Roberts, DDS, LLC, its private contractors and employees all rights to exhibit this work in print and electronic form, publicly or privately.

I understand that there will be no financial compensation for use of such media.

I represent that I am at least 18 years of age, have read and understand the foregoing statement, and I am competent to execute this agreement.

Name: _____ Date: _____

Address: _____

Phone: _____

Witness for the undersigned: _____

Signature: _____

*I give my permission to have my name/identity revealed at the discretion of Don Roberts, DDS, LLC. Please check here. ☐