



**Authorization for Photography, Interview, and/or Video
Release of Information for Media Purposes**

Ohio State College of Dentistry
Marketing and Communications Department

I, _____ (patient or guardian), voluntarily give my permission for my likeness/image, voice, and/or information gathered in interviews, photographs, film, or videotape (“Images”) of me about my dental conditions, treatment, and identifying information—including, but not limited to, my name, age, and gender—to be used by news media, College of Dentistry staff, the ADA Foundation, the American Dental Association and the Ohio Dental Association (collectively, the “Organizations” and individually, an “Organization) or their representatives for the communications of events, programs, services, and procedures; and any educational, promotional, advertising, fundraising, or commercial purpose, or any other purposes whatsoever including in news releases, publications, and web sites. Any Organization has the right and may allow others outside the Organization to copy, edit, alter, retouch, revise, and/or otherwise change the Images at the Organization’s discretion. In addition, an Organization my permit GKAS program sponsors to use the Images in furtherance of Give Kids A Smile. All right, title, and interest in the Images belong solely to the Organization taking the Images. I understand once materials are released to the media or printed or posted, Ohio State’s College of Dentistry retains no further control over their use.

I, _____ (patient or guardian), voluntarily give my permission for dental information regarding my dental condition or treatment to be released to the news media, dental college staff, or their representatives for their use. I understand once materials are released to the media or printed and posted, the College of Dentistry retains no further control over their use.

I understand that this information may no longer be protected by federal privacy rules such as the HIPAA Privacy Rule or other confidentiality protections. I have been offered the opportunity to ask questions, or have this form read to me. I understand that I may revoke this authorization, in writing, at any time to the Marketing and Communications department at the address above. Any revocation will not apply to information that has already been released or used. I also understand that I am not required by The Ohio State University College of Dentistry to agree to the use of or release of information or images described above and that I am not required to sign this form as a condition of treatment.

Participant: patient (or guardian), student, faculty, staff, other _____ Date _____

Mailing Address: _____

Daytime Phone Number: _____