Dentist and Laboratory Technician
Credentialing Patient Authorization to Release of Material
(Must be included with each Clinical Case Report submitted)

I am a patient of Dr. _____ (my dentist). My Lab Technician is _____ (Laboratory Technician Name). I understand that my dentist and my lab technician may be a member in the process for Accreditation by the American Academy of Cosmetic Dentistry®, Inc. (the "AACD"). I understand that the purpose of this authorization is so that my dentist/laboratory technician may submit photographs, slides and similar materials (collectively, the "material") for use in the AACD Accreditation process and/or for the AACD's purposes. I understand that the material may identify me. I hereby authorize my dentist and laboratory technician and the AACD, its officers, agents, employees, and affiliates, to use any or all of this material for AACD's purposes, including without limitation: in AACD publications and advertisements; on web sites and exhibit booths; and in educational programs and related documentation and templates. This authorization shall apply to any successor or assignee of AACD. I understand that I have the right to request restrictions on the disclosure of the material by notifying my dentist/laboratory technician. Cases suitable for submission for Accreditation, must be submitted without restrictions or limitations placed on the Photographic Release Form.

I understand that while the AACD and its agents will attempt to provide high-quality reproduction of my photos, the reproduction quality is not guaranteed. 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 use of the material will not include my full name and that the material may be used in individual or composite form. I understand that the material may be modified by AACD 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.

This authorization will expire ten years after the date I approve the authorization. I may revoke the authorization prior to that time period but any such revocation will not affect uses or disclosures of the material that have already occurred or have already been determined to occur in the future. For example, if the material is published in a brochure, the brochures created prior to the revocation or expiration will not be recalled and additional brochures may be created and the material used until the next overall update of the brochure. I can revoke this authorization by providing notice to my dentist/ laboratory technician. 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 understand that my dentist and laboratory technician are not conditioning treatment or eligibility for benefits on whether I grant this authorization. I hereby release my dentist/ laboratory technician and the AACD, its officers, agents, employees, and, affiliates from any and all liability for using the material as described in this authorization. I may receive a copy of the signed authorization upon request.

_____ _____ **Sign & Date**
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 Patient: _____

Circle one

Check Case Type: ☐ Case 1 ☐ Case 2 ☐ Case 3 - Bridge or Implant ☐ Case 4 ☐ Case 5 **Complete**

Check Submission Session: ☐ June 2025 ☐ November 2025 **Complete**

Member ID: _____ **Complete**

Dentist/ Laboratory Technician / Photographer Consent to Release of Material

I am submitting photographs, slides and other materials (collectively, the "material") to the American Academy of Cosmetic Dentistry®, Inc. (the "AACD") as part of the AACD Accreditation process or for other AACD purposes. I hereby represent to the AACD that I have the authorization of the patient, _____ [*Insert patient name*], to use the material and provide it to AACD for its uses, including without limitation: in AACD publications and advertisements; on web sites and exhibit booths; and in educational programs and related documentation and templates. If the patient revokes his or her authorization I will immediately provide written notice of the revocation to AACD. I hereby give my consent and permission to the AACD, its officers, agents, employees, and affiliates, to use any or all of this material in such manner. I understand that I will receive no compensation for use of the material described in this consent. My consent is freely given to the extent permitted under applicable law. I hereby release and indemnify the AACD, its officers, agents, employees, and affiliates from any and all liability for using the material as described in this consent. This release shall apply to any successor or assignee of AACD. I understand that the patient authorization provided by the AACD may not incorporate all applicable law and that I may contact my own legal counsel to review the authorization and this consent.

Photographer Release: Check (1) the first box if the dentist/laboratory technician is the photographer; (2) the second box if another person (such as a professional photographer) is the photographer.

o I certify that I am the photographer of the attached images taken of the patient. I am the sole owner of all copyrights in said images, and own all right, title and interest thereto. (The default shall be this box if no box is checked.)
o Another person, identified below as the photographer, is the photographer and owner of all copyrights in said images and owns all right, title and interest thereto. I certify that I have obtained the photographer's signature, below, and agreement to this consent.

For good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the photographer identified below or the dentist/laboratory technician hereby grants a non-exclusive perpetual worldwide royalty-free license to the AACD, an authorized agent of the AACD or any successor or assignee of AACD, to reproduce, publish, copy or prepare derivative works based upon the attached images for any of the purposes described above.

There are no limitations on the type of media that may be used by AACD for the above purposes. All rights not expressly granted herein are retained by the photographer.

_____ _____
Dentist Signature Date

Sign & Date

_____
Print Dentist Name

_____ _____
Laboratory Technician Signature Date

_____
Print Laboratory Technician Name

Complete only if dentist or laboratory technician is not the photographer:

_____ _____
Photographer Signature Date

Sign & Date

_____
Print Photographer Name

Circle one

Complete

Check Case Type: ☐ Case 1 ☐ Case 2 ☐ Case 3 - Bridge or Implant ☐ Case 4 ☐ Case 5

Check Submission Session: ☐ June 2025 ☐ November 2025

Complete

Member ID: _____

Complete