

**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. [redacted] (my dentist). My Lab Technician is [redacted] (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.

[redacted]

Patient’s Signature

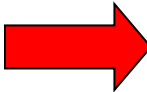
[redacted]

Date



[redacted]

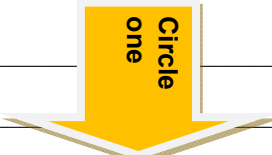
Print Patient’s Name



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: _____



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



Check Submission Session: June 2025 November 2025



Member ID: _____



