Marketing Release Agreement

Jai H. Shin, D.D.S.
200 West 57th Street, Suite 704
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Telephone: +1 (212) 433-1991
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Email: info@LuxSmilesNYC.com

PHOTOGRAPHY CONSENT

I, ____________________________________, hereby authorize Jai H. Shin, D.D.S. and Lux Smiles (Forthwith referred to in this agreement as Health Care Provider) to take and use my before and after photos, videos, and/or portrait of my face, jaws and teeth, with or without my name, or with a fictitious name (my protected health information).

I understand the photographs will be used as a record of my care, and may be used for educational purposes in lectures or viewing by other dental professionals, demonstrations to other patients, advancement of cosmetic dentistry, marketing efforts in promotion of cosmetic dentistry to include publication, websites and professional publications.

I further understand that if the photographs are used in any publications, marketing or websites as part of a demonstration or lecture, all reasonable attempts will be made to conceal my surname and/or identity.

______________________________	______________________________
Signature of Patient or Personal Representative	Name of Patient or Personal Representative
______________________________	______________________________
Date	Description of Personal Representative's Authority

AUTHORIZATION TO USE TESTIMONIAL REMARKS

I, ____________________________________, hereby authorize Jai H. Shin, D.D.S. and Lux Smiles (Forthwith referred to in this agreement as Health Care Provider) to use textual information such as testimonial remarks, clinical discussions, or treatment information including descriptions that I have provided for use in publications, websites or as part of a demonstration, marketing or lecture.

I further authorize the use of my first name and my last name initial (e.g. Jane D.) to identify me as the source of this testimonial.

______________________________	______________________________
Signature of Patient or Personal Representative	Name of Patient or Personal Representative
______________________________	______________________________
Date	Description of Personal Representative's Authority

AUTHORIZATION TO DISTRIBUTE NAME AND NUMBER

I, ____________________________________, hereby authorize Jai H. Shin, D.D.S. and Lux Smiles (Forthwith referred to in this agreement as Health Care Provider) to give my name and phone number as a reference or testimonial source for other patients who may have questions regarding similar types of care as I have experienced. The phone number that should be used to contact me is __________________________________.

______________________________	______________________________
Signature of Patient or Personal Representative	Name of Patient or Personal Representative
______________________________	______________________________
Date	Description of Personal Representative's Authority

RIGHT TO REVOKE

I, ____________________________________, understand that I have the right to revoke this authorization, in whole or in parts, in writing, at any time by sending such written notification to Jai H. Shin, D.D.S. and Lux Smiles (Forthwith referred to in this agreement as Health Care Provider) address at:

Mailing Address: 200 West 57th Street, Suite 704, New York, NY 10019, U.S.A.

Email Address: info@LuxSmilesNYC.com

I understand that such a revocation is not effective to the extent that the Health Care Provider has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.);
- Refuse to sign this authorization.

I have signed a consent form of Health Care Provider and have been made aware of the Health Care Provider "Notice of Privacy Practices." The statements included in this authorization are binding on the Health Care Provider.

The use or disclosure requested under this authorization may result in direct or indirect remuneration to the Health Care Provider from a third party.

______________________________	______________________________
Signature of Patient or Personal Representative	Name of Patient or Personal Representative
______________________________	______________________________
Date	Description of Personal Representative's Authority