

*Photo Release Form*

*Master's Hand Dental*

935 W. Exchange Pkwy., Ste#300  
Allen, TX 75013

Permission to use photograph

Subject: \_\_\_\_\_

Location: \_\_\_\_\_

I grant to Master's Hand Dental, its representatives and employees the right to take photographs of me and my property in connection with the above-identified subject. I authorize Master's Hand Dental, its assigns and transferees to copyright, use and publish the same in print and/or electronically.

I agree that Master's Hand Dental may use such photographs of me without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and web content.

I have read and understand the above:

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Organization Name (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_

Date: \_\_\_\_\_

Signature Parent or Guardian: \_\_\_\_\_

(if under age 18)