Richard W. Bowen, DDS
family & cosmetic dentistry

Patient Testimonial/Photo Release Form

Thank you for taking time from your busy schedule to give a video and/or written testimonial about Dr. Bowen and our dental office.

I hereby authorize Dr. Bowen to use my name, comments, photos, video testimonial, video slides or any other image as may be necessary of me (in complete or edited form), with or without my given name and city for marketing, training, education or any other *lawful purpose* and I release and forever discharge said Dr. from any claim, demands or liability on account of such use or for the quality of the reproduction of the photograph or photocopy provided.

Name of patient: _____

Signature of patient: _____

City and State patient resided: _____

Date: _____

770 Jasonway Ave. ■ Columbus, OH 43214 ■ ph 614.459.2300 ■ fax 614.442.0068 ■ www.richardbowendds.com