**PATIENT INFORMED CONSENT AND RELEASE AGREEMENT**
**FOR USE OF MATERIALS ("RELEASE")**

I, _____ ____, hereby agree and consent as follows:

I acknowledge that my doctor _____ ("Doctor") intends to submit information relating to my dental case history, which may include photographs, PVS impressions, study models, ClinCheck records, radiographs (x-rays), dental records, as well as Doctor name, my name, demographic information, candid and/or lifestyle photographs, my likeness, quotations, statements and/or testimonials ("Materials"), to Align Technology, Inc. ("Align") for various uses which include, (i) educational and training purposes; (ii) marketing and sales promotions; and (iii) clinical and research programs (hereinafter the "Invisalign Program(s)"), regardless of media, including but not limited to print and online advertising. I understand that Doctor may be compensated by Align for this submission.

My signature below provides Doctor with authorization to send Align the Materials. I hereby grant to Align, a worldwide, perpetual, right and license to use, copy, display, incorporate into derivative works, and distribute the Materials in connection with the Invisalign Program. In addition, I agree that Align may use the information provided by my Doctor for the Invisalign Program provided my name is not identified. Any use outside of this Informed Consent Agreement must be pre-approved by me in writing.

I ACKNOWLEDGE THAT I WILL NOT RECEIVE COMPENSATION FOR ANY SUBMISSIONS THAT ALIGN ACCEPTS, AND I WILL NOT, NOR SHALL ANYONE ON MY BEHALF HAVE OTHER CLAIM(S) OF COMPENSATION, HAVE ANY RIGHT OF APPROVAL, OR SEEK OR OBTAIN LEGAL, EQUITABLE OR MONETARY DAMAGES OR REMEDIES ARISING OUT OF ANY USE OF THE MATERIALS THAT COMPLY WITH THIS AUTHORIZATION.

It is expressly agreed that Align shall have a worldwide, royalty-free, and perpetual right to copy, distribute, prepare derivative works from, and publicly perform, show, and/or display the Materials or any portion or version thereof.

ON BEHALF OF MYSELF AND EACH OF MY SUCCESSORS, ASSIGNS, HEIRS, BENEFICIARIES, AND ALL OTHERS CLAIMING BY, UNDER, OR THROUGH ME, HEREBY RELEASES, COVENANTS NOT TO SUE, ACQUITS, AND FOREVER DISCHARGES ALIGN, ITS OFFICERS, DIRECTORS, STOCKHOLDERS, ATTORNEYS, EMPLOYEES, AGENTS, SUCCESSORS, AND ASSIGNS, FOR ANY AND ALL LIABILITY AND ANY AND ALL CLAIMS, CAUSES OF ACTION, DEMANDS, OR CONTROVERSIES, WHETHER KNOWN OR UNKNOWN, WHICH I NOW HAVE, OR MAY HEREAFTER HAVE, WHICH ARISE FROM OR RELATE OR PERTAIN, IN WHOLE OR IN PART, IN ANY MANNER TO THE MATERIALS, SPECIFICALLY INCLUDING BUT NOT LIMITED TO DEMANDS, CLAIMS, CONTROVERSIES OR CAUSES OF ACTION BASED IN WHOLE OR IN PART ON ANY RIGHTS OF PUBLICITY, INVASIONS OF PRIVACY, PORTRAYALS IN A FALSE LIGHT, DEFAMATION, COPYRIGHT, MORAL RIGHTS, MENTAL DISTRESS, AND ANY OTHER LIABILITY, WHETHER SIMILAR OR DISSIMILAR TO ANY OF THE FOREGOING. ALIGN IS PERMITTED, ALTHOUGH NOT OBLIGATED, TO INCLUDE MY NAME AS A CREDIT IN CONNECTION WITH THE MATERIALS. ALIGN IS NOT OBLIGATED TO UTILIZE ANY OF THE RIGHTS GRANTED IN THIS AGREEMENT.

I shall have no right of approval, no claim of compensation, and no claim to legal damages arising out of any use set forth herein of the Materials or any discussions by my Doctor surrounding the Materials.

I have read and understand this Informed Consent and Release Agreement.

_____
Patient Signature

_____
Print Name

_____
Patient Date of Birth

_____
Address

_____
Date

_____
Witness Signature

_____
Print Witness Name

_____
Date

If signatory is under 21 or lacks the legal capacity to sign, the parent or Legal Guardian must also sign below to signify the agreement:

_____
Signature of Parent/Guardian

_____
Print Name

_____
Date

Authorization for the Release of Protected Health Information
"HIPAA Release"

**I give permission for**:_____
(physician's office)

**To release:** photos / videoclip relating to Invisalign treatment and experience.

**To:** Align Technology, Inc. (makers of Invisalign)

**For purposes of:** Marketing, education, training, research, product development, and/or quality assurance.

I understand that in signing this release:

- That if I want to revoke my authorization, I must contact Align in writing at privacy@aligntech.com. I know that if Align has already relied upon my authorization, my revocation will only affect future use of my information.
- If the organization I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by HIPAA. Other privacy laws may still apply.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily: treatment, payment, or eligibility for my benefits will not be affected if I do not sign this authorization.

This release (permitting the doctor to share my information) shall expire one year from the date it is signed. This does not impact any other releases I may have signed with Align.

_____
Patient Signature

_____
Patient Printed Name

_____
Date Signed

_____
Relationship to Patient (if not signed by Patient)