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

I hereby agree and consent as follows:

1. I acknowledge that my doctor, _____ ("Doctor") intends to submit, or has already submitted information to Align for the manufacture of my Invisalign aligners, plus additional information relating to my dental case history, which may include photographs, ClinCheck records, radiographs (x-rays), dental records, as well as Doctor name, my name, demographic information, likeness, quotations, statements and/or testimonials (collectively, the "Materials"), to Align Technology, Inc. ("Align") in connection with the Invisalign Gallery University Challenge ("Invisalign Program"). I understand that if selected, Doctor may be compensated by Align for presenting this submission at an education event.

2. 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 and my eyes are blocked out on photos. Any use outside of this Informed Consent Agreement must be pre-approved by me in writing.

3. I understand that submission of the Materials for the Invisalign Program may result in disclosure of my "individually identifiable health information," and I have provided my doctor with any necessary permissions.

4. I ACKNOWLEDGE THAT I WILL NOT RECEIVE COMPENSATION FOR ANY SUBMISSIONS THAT ALIGN ACCEPTS.]

5. 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.

6. 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.

6. 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 my Dental Records or any discussions by my Doctor surrounding such records.

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

_____
Signature

If patient does not have the legal capacity to sign, the parent or Legal Guardian must also sign below to signify agreement:

_____
Print Name

_____
Signature of Parent/Guardian

_____
Print Name

_____
Address

_____
Address, if different from Paitent's

_____
City/State/Zip Code

_____
City/State/Zip Code

_____
Telephone #:

_____
Telephone #

_____
Date Signed

_____
Date signed

align

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)