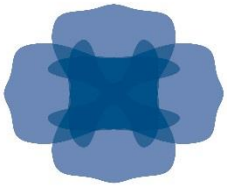

Riverside Dental Group and Dental Associate offices

Media Release and HIPAA Authorization

By signing below (or the signature of my parent or legal guardian), I hereby acknowledge that:

(i) I have been asked to participate in certain media and advertising activities of Riverside Dental Group and Dental Associate offices. Such image, sound capture and subsequent display in any medium including print, video or audio, web-based or any other form of distribution shall be hereafter referred to as the "Media" to be produced by the Practice, or on behalf of the Practice by its subcontractors ("Media Consultants).

(ii) As a result of my participation in the development and creation of the Media, it will be necessary for the Practice and the Media Consultants to use and portray my name, likeness, picture, image, voice, personality and Protected Health Information ("PHI") (defined below) (collectively, "Name, Image, and Health Information") in connection with the development, distribution, promotion and advertising associated with the Media.

(iii) The Federal Health Insurance and Portability and Accountability Act ("HIPAA") requires that patient review and sign a written authorization before the Practice may use or disclose PHI for purposes other than treatment, payment or health care operations. HIPAA defines PHI as "individually identifiable health information." Generally this information is created or received, whether oral or recorded in any form or medium, by a health care provider in the course of patient treatment and includes a patient's name, age, address, gender, race, marital and insurance status related to the past, present or future condition or treatment of an individual. Under HIPAA, full face photographic images and comparable images are considered PHI.

(iv) By reviewing and signing this Media Release and HIPAA Authorization, I am authorizing the Practice to use or disclose my Name, Image and Health Information or the Name, Image and Health Information of a patient for whom I am the parent, guardian or personal representative, as specified below.

FOR VALUABLE CONSIDERATION THE RECEIPT AND SUFFICIENCY OF WHICH I HEREBY ACKNOWLEDGE:

1. I hereby grant to the Practice, its subsidiaries, affiliates, licensees, employees, dental staff, business associates, agents and successors and to any persons or entities authorized by the Practice (collectively the "Practice Group"), the right to use, disclose and portray my Name, Image and Health Information in connection with the development, creation, advertising and promotion of the Media in all forms and in distribution channels of any kind, whether now known or hereafter devised, worldwide, in perpetuity and to disclose my PHI to the Media Consultants. I understand that the Practice Group and the Media Consultants intend to use and disclose my Name, Image and Health Information in connection with the development, creation, advertising and promotion of the Media and to make derivative works therefrom as the Practice Group and the Media Consultants shall deem appropriate in their sole discretion.

2. I hereby release, remise and forever discharge the Practice Group from any and all past, present and future causes of action, claims for damages, compensation, liability or obligation for libel,

defamation, invasion of privacy or right of publicity, copyright infringement or any other right relating to the use of my Name, Image of Health Information (actual, modified or simulated) in connection with development, creation, advertising and promotion of the Media and any derivative works therefrom.

3. This Media Release and HIPAA Authorization contains the entire agreement and understanding between the Practice and me regarding the subject matter hereof. No oral understandings have been made with me regarding the Media, and this Media Release and HIPAA Authorization may be amended only by a written instrument signed by the Practice and me.

4. I understand that this Media Release and HIPAA Authorization shall be binding on me, my successors, assigns, heirs, executors and administrators.

5. PURSUANT TO FEDERAL LAW, I MAY REFUSE TO SIGN THIS AUTHORIZATION. IN SUCH EVENT, MY CONTINUED TREATMENT WILL NOT BE CONDITIONED ON MY SIGNING OR REFUSING TO SIGN THIS AUTHORIZATION. IF I REFUSE TO SIGN THIS AUTHORIZATION, I MAY NOT BE PERMITTED TO PARTICIPATE I ANY ASPECT OF THE MEDIA.

6. I may inspect or obtain a copy of the PHI that I am being asked to authorize for disclosure or use in the Media. To inspect this PHI, I should contact the Practice at 951-689-5031.

7. This Media Release and HIPAA Authorization shall expire when the Media or the derivative works therefrom are no longer distributed, or in use by the Practice Group or the Media Consultants even if I shall be deceased prior to that time.

8. I hereby covenant, agree and acknowledge that the Practice shall be the exclusive owner of the Media and all derivatives thereof, the copyrights pertaining thereto and any and all other rights, benefits or privileges arising there from now and hereafter in perpetuity throughout the universe without limitations.

9. I may revoke this Media Release and HIPAA Authorization at any time prior to the time the Practice Group has relied thereon. Any revocation shall be signed by me or on my behalf and delivered to the Practice at: 7251 Magnolia Avenue, Riverside, CA 92504. My revocation shall be effective upon receipt, except to the extent that the Practice Group has acted in reliance upon this Media Release and HIPAA Authorization. I understand and agree that the Practice Group will be deemed to have acted in reliance upon this Media Release and HIPAA Authorization upon the use and/or disclosure of my PHI in accordance with the Authorization.

10. I have a right to receive a copy of the Media Release and HIPAA Authorization.

(Signature page follows)