

Disclaimer: This document and the information in it does not constitute legal advice. It is also not a substitute for legal or other professional advice. Users should consult their own legal counsel for advice regarding the application of the law and this document as it applies to the HIPAA regulations.

AUTHORIZATION FOR USE OF DISCLOSURE OF INFORMATION FOR MARKETING PURPOSES

I, _____, hereby authorize _____
(Forthwith referred to in this agreement as **Health Care Provider**) to use my before and after photos, videos, and/or portrait and related textual information such as testimonials, clinical discussions, or treatment information including descriptions with or without my name, or with a fictitious name (my protected health information).

This protected health information is being used or disclosed for the purpose of marketing or as (s)he sees fit for the advancement of cosmetic dentistry, educational viewing by other dental professionals, and in the promotion of cosmetic dentistry.

This authorization shall be in force and effect until January 1, 2028 at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the **Health Care Provider's** address at:

Mailing Address: _____

Email Address: _____

I understand that such a revocation is not effective to the extent that the **Health Care Provider** has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

I have signed a consent form of **Health Care Provider** and have been made aware of the **Health Care Provider** "Notice of Privacy Practices." The statements included in this authorization are binding on the **Health Care Provider**.

The use or disclosure requested under this authorization will result in direct or indirect remuneration to the **Health Care Provider** from a third party.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority