Authorization for Release/Use of Protected Health Information in the Form of Photo's, Radiographs, and Electronic Images

FAMILY DENTISTRY OF COLUMBUS

Your photos and x-rays are part of your diagnostic and clinical record and are considered to be protected health information under federal HIPAA Privacy Laws.

We make us of radiograph (x-rays), photographs, and digital images. These images may be used for diagnosis, documentation, reference, teaching, and research publication. Some cases that present exceptional results, particularly remarkable smiles, or interesting situations, may be utilized for demonstration, education or advertising to potential and existing patients in our office either in print media, television, on digital medial and on our webpage. In some instances, you may be recognizable in some of these images.

By initialing and signing this form, you are authorizing us and releasing us from any liability resulting from the use/release of such images. Your authorization and release to use images will in no way affect the quality of your results in our office. We do our best to provide exceptional dentistry to all patients.

_____I authorize the use of my images where my face is identifiable

_____I authorize the use of my images where only my teeth are identifiable

_____I authorize the use of my radiographs

The purpose of this request to release and/or disclose the PHI described above is for personal reasons. I understand that I have the right to revoke this Authorization, in writing, at any time by notifying the office above. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation. I also understand information discloses pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by this rule.

I understand that my health care provider cannot condition treatment on whether I sign this Authorization. This Authorization will expire at such time that:

_____I determine that I no longer wish for my images to be used and I revoke this authorization in writing; or

_____The following date: _____ (within one year of current date).

_____
Print Name (Patient or responsible party)

_____ _____
Signature (Patient or responsible party) Date