Managing Marketing

ADA's Guidelines for Practice Success™ (GPS™)

SAMPLE AUTHORIZATION FORM FOR USE OR DISCLOSURE OF PATIENT INFORMATION

The following is sample HIPAA authorization for using patient photos for a dental practice marketing campaign. If the dental practice will receive remuneration or compensation in connection with the use of the photos, this form may require additional disclosures.

Patient Name: _____

Patient's Date of Birth: _____ Patient's Chart No.: _____

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Specific description of the patient information to be used or disclosed:

Any photos of me, including full-face photos and comparable images

Purpose(s) of this use or disclosure:

Any lawful purpose, including but not limited to dental practice marketing, such as print and online advertising, the dental practice website, and practice newsletters.

I authorize the following person(s) to make this use or disclosure:

Any dental practice workforce member or vendor.

The following person(s) may receive this patient information:

The public at large, including but not limited to publications and their readers, website companies, website visitors, advertising firms and other companies.

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice at the following address: **[insert address]**.

If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

This authorization expires at the end of any marketing campaign, or when the photos are no longer required for marketing or other purposes.

Signature of Patient or Patient's Personal Representative:

_____Date_____

If signed by the patient's personal representative:

Print Name: _____

Signature: _____ Relationship to Patient: _____

For office use only: A copy of signed authorization was provided to the individual:
Date: _____
Initials: _____