Authorization for Release of Information – Media

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| **Patient Name:** |
| **Patient Date of Birth:** |
| **Hilltop Dental Studio is authorized to release protected health information as described below for the identified patient.** |
| **Use still, audio and video images with my likeness for the purposes of (Check all that Apply):**  **Facebook**  **Instagram**  **Twitter**  **Practice Website**  **Advertising**  **Before and After Photos**  **Posted/Streamed in Office** |
| **Patient Rights:**   1. I have the right to revoke this authorization at any time. 2. I may inspect or copy the protected health information to be disclosed as described in this document. 3. Revocation is not effective in cases where the information has already been disclosed but will be effective going forward. 4. Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. 5. I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing*.* |
| This authorization will remain in effect until I revoke it in writing, or on the date listed below: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Patient or Personal Representative  Description of Personal Representative’s Authority (attach necessary documentation) :  Mother  Father  Legal Guardian |
| Date this Authorization Expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |