Kids n More DENTIST

Authorization for Release/Use of Protected Health Information In the Form of Photos, Videos, Radiographs, and Electronic Image

Photos, videos, radiographs and electronic images are part or your diagnostic and clinical record and are considered to be protected health information ("PHI") under federal HIPAA Privacy Laws.

Authorization:
I authorize Rackham Dental, PLLC, d/b/a Kids n More Dentist ("Kids n More") to take photographic/video images. Further, I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by Rackham Dental, PLLC d/b/a Kids n More Dentist ("Kids n More"). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA privacy regulations.

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

Purpose:
The purpose of this request to release and/or disclose the PHI described above is for personal reasons. The photographic/video images, and/or testimonial will be used for: advertising to potential and existing patients in our office either in print media, social media, television, on digital media and on our webpage.

Revocability:
I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by Kids n More via registered mail at 6658 Summer Fest Dr., Ste. 104, San Antonio, Texas 78244. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 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*).

No Treatment Conditions:
I understand that Kids n More cannot condition treatment on whether or not I sign this authorization.

Patient

Name:_____

Date:_____

Signature:_____

If Personal Representative

Name:_____

Date:_____

Signature:_____

Relationship to Patient:_____

If Patient is a Minor

Parent/Legal Guardian:_____

Date:_____

Signature:_____