AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: ______________________________ DOB: ______________

Turner Orthodontics is authorized to release protected health and/or financial information about the above named patient in the following manner and to identified persons.

ENTITY TO RECEIVE INFORMATION

Please identify persons (ie. parents, family, babysitters) who may be accompanying the patient who are approved to receive information.

INFORMATION TO BE RELEASED

Check type of information that can be given to corresponding person on the left.

Name	Relationship to patient	TREATMENT	FINANCIAL	ALL
______	______	☐	☐	☐
______	______	☐	☐	☐
______	______	☐	☐	☐
______	______	☐	☐	☐

We may send private health information such as: financial details, treatment details, appointment reminders, procedure instructions and breach notifications to your email, cell phone, and/or your answering machine/voicemail. Please indicate the types of communication you are willing to receive.

❑ ANSWERING MACHINE/VOICE MAIL Any number listed on Patient Information Sheet.

❑ EMAIL(S)* ______________________________

❑ TEXT* *Provide cell number(s)* ______________________________

*For email and/or text communication, I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

PATIENT RIGHTS This authorization will remain in effect until revoked by the patient.

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- 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.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

______________________________ Date ______________

SIGNATURE OF PATIENT (OR LEGALLY AUTHORIZED INDIVIDUAL)

______________________________ ______________________________

PRINTED NAME OF PARENT OF GUARDIAN (IF SIGNING) RELATIONSHIP TO PATIENT (PARENT, LEGAL GUARDIAN, ETC.)

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: ____ DOB:____________________

We maintain an office page on Facebook, Instagram and Snapchat. The purpose of these social media posts is to stay connected with patients and their families. This provides a fun way to share the goings on in our office as well as update you on important information.

AUTHORIZATION

By signing below, I affirm, as a patient of Turner Orthodontics named above OR as the parent or legal guardian of a minor child that is a patient of Turner Orthodontics (the "Patient"), that I authorize Turner Orthodontics: (i) to capture photographic or video images of the Patient (the "Images"); (ii) to reproduce, use, and disclose the Images, with or without the Patient's name; (iii) to publicize the fact that medical services were provided to the Patient; (iv) to reproduce and publish any testimonials the Patient provides regarding Turner Orthodontics (collectively referred to herein as the "Information"); and (v) to secure copyright registration for any materials that incorporate the Information, at the election and sole expense of Turner Orthodontics. The authorization is given to Turner Orthodontics, for disclosures to any persons, without limitation, who may view the Information in printed or digital form in promotional materials including social media or Internet sites and I waive any right that I may have to inspect and/or approve the finished product.

PURPOSE

The purpose of this authorization is to permit the Information, including Images, to be used for marketing of Turner Orthodontics, and I explicitly consent to the use of Information for advertising and marketing activities to promote Turner Orthodontics. I acknowledge and agree that no compensation will be provided for the use of the Information.

PATIENT RIGHTS *This authorization will remain in effect until revoked by the patient.*

- I have the right to revoke this authorization at any time.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- 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.

Please check one of the boxes then sign your name(s)

☐ CONSENT: I/we hereby certify that I/we am/are the parent(s) or guardian(s) of the above named Patient and do hereby give my/our consent without reservation to the foregoing on behalf of the Patient.

☐ NON-CONSENT: I/We hereby certify that I/we am/are the parent(s) or guardian(s) of the above named Patient and do not hereby give my/our consent without reservation to the foregoing on behalf of the Patient.

______________________________________ Date________________________
SIGNATURE OF PATIENT

SIGNATURE OF PARENT/LEGAL GUARDIAN	PRINTED NAME OF PARENT/LEGAL GUARDIAN	RELATIONSHIP TO PATIENT
SIGNATURE OF PARENT/LEGAL GUARDIAN	PRINTED NAME OF PARENT/LEGAL GUARDIAN	RELATIONSHIP TO PATIENT