SHELBY DENTAL

FAMILY — COSMETIC

Authorization for Use and Disclosure of Protected Health Information

Authorization: By my signature below, I affirm, as a patient of Shelby Dental OR as the parent or legal guardian of a minor child that is a patient of Shelby Dental (the "Patient"), that I authorize Shelby Dental: (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 Shelby Dental (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 Shelby Dental. The authorization is given to Shelby Dental, 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.

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

Expiration and Revocability: If Patient is signing on his or her own behalf, this authorization expires when the Patient informs Shelby Dental that he or she is no longer a patient of Shelby Dental. If Patient is signing on behalf of a minor child, this authorization expires when the Patient reaches the age of majority, but the authorization remains valid for protected health information already used or disclosed until revoked by the Patient who has attained majority. However, I understand that protected health information already used or disclosed prior to any revocation may no longer be protected. I understand that I may revoke this authorization at any time by notifying Shelby Dental by Certified Mail, return receipt requested, but that revocation will only affect uses and disclosures initiated after the date notice is received by Shelby Dental. Upon receipt of the notice of revocation, Shelby Dental will make reasonable efforts to remove protected health information from social media platforms over which it has control, but cannot guarantee removal from all sites. I understand and explicitly acknowledge that the Internet allows for wide sharing and forwarding of information, and that Shelby Dental cannot control all re-disclosure of information.

No Effect on Treatment: This authorization is voluntary. I understand that Shelby Dental cannot condition treatment of the Patient on whether I sign this Authorization, and that my decision not to sign will not influence or affect the Patient's treatment in any way.

Name of Patient: _____

Date of Birth of Patient: _____

Signature of Patient OR
Parent/Legal Guardian: _____
(if signing for minor)

Printed Name of
Parent or Guardian: _____
(if signing on behalf of minor child)

Date of Signature: _____