Authorization for Use or Disclosure of Patient Photographic and/or Video Images

Authorization: I authorize the use and disclosure of my name, photographic/video images, and/or testimonial, including any medical information contained therein, to Magnolia Falls Oral Surgery (Dr. or practice name), it's business associates, employees, licensees, and successors. 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 and the HITECH Act.

Purpose: The photographic/video images, and/or testimonial will be used for Social Media and/or Advertising

Revocability: I understand that I may revoke this authorization at any time, but such revocation must be in writing and received via registered mail. Revocation affects disclosure moving forward and is not retroactive.

No Treatment Conditions: I understand that my practitioner cannot condition treatment on whether or not I sign this authorization.

If desired, copy provided:

"Yes, I would like a copy of this form." (initialed by team member, copy provided by ________________)

Dr. or Practice Name: Brett Shigley DMD, MS / Magnolia Falls Oral Surgery

Patient Name: ______________________________

Date: ______________________________

Signature: ______________________________

If Personal Representative:

Name: ______________________________

Date: ______________________________

Signature: ______________________________

Relationship to Patient: ______________________________

If Patient is a Minor:

Parent / Legal Guardian: ______________________________

Date: ______________________________

Signature: ______________________________

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