Photography Consent Form

Muscaro & Martini Dentistry
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MUSCARO & MARTINI DENTISTRY AUTHORIZATION FOR THE USE OF PHOTOGRAPHY TESTIMONIALS AND MARKETING INFORMATION

In connection with the healthcare services that I shall be receiving, I (patient's name) _____ do hereby authorize photography (using current and accepted methods) may be taken of me or parts of my body (as defined by my healthcare provider), under the following conditions:

1. My healthcare provider may take the photography or it may be taken by a designee approved by my healthcare provider who has signed a HIPAA required Business Associate Agreement with my healthcare provider. ¬

2. The photography shall be used for medical records and if, in the judgement of my healthcare provider, medical research, education or science will be benefitted by its use, such photography and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purpose which he/she may deem proper in the interest of medical education, knowledge and research. It is specifically understood that in any such publication or use, all reasonable effort will be made so that I shall not be identified by name. I understand I may be recognized and identifiable in the photography. All reasonable efforts will be made to avoid personal identification.

3. I authorize my healthcare provider to use testimonials given by me, or photography taken of me, for marketing purposes. I understand this information may be posted on social media outlets, the providers' website or used as directed by my healthcare provider. This information will be used only in a professional and ethical manner as directed by my healthcare provider. I have the right to request that my health care provider inform me prior to using any information for marketing or non-healthcare related purposes.

4. I authorize my healthcare provider to send information to me, either electronically or through a mail service, about products or services the practice may now or in the future provide that may be of interest to me.

5. I understand I have the right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization, or, if applicable , during a contestability period. In order for the revocation of this authorization to be effective, we must receive the revocation in writing. The revocation must include:

    - The patient's full name and address
    - The patient's desire to revoke this authorization
    - The effective date of this revocation
    - The patient's and/or patient's agent/representative's signature
    - The relationship to the patient, if applicable

    ** We will accept written revocations of this authorization by Certified U.S. mail only.

    This authorization shall be non-expiring except as listed below.

    If this authorization is to be used solely for marketing purposes, then this authorization shall expire on: DATE _____
    After this date, we can no longer use or disclose your protected health information without first obtaining a new authorization form.

    I fully understand and accept the terms of this authorization.

Signature:

_____ _____

Patient's Signature | Patient's Agents/ Representative's Signature & Relationship

_____ _____

Signature of Witness | Date