Coastal
Orthodontics

Authorization to Release Health Information

I, _____, hereby authorize _____ (name of practice) located in _____ (city and state) to disclose the face photograph of the following patient to the general public by posting it on a bulletin board or other area in the practice's office:

Patient Name: _____
Address: _____
_____
_____

Patient Soc. Sec. No. or practice's record number for the Patient:
_____

___ The practice will post the patient's picture for the purpose of informing other patients of the positive outcome we have achieved. The practice is not receiving any compensation from you or anyone else for this picture, and it will not be used outside of the office.

___ Other issue: _____
_____
_____

2. Revocation. I understand that I may revoke this authorization at any time by sending a written notice to the practice. We will take down the picture at the time we receive the revocation.

3. Expiration. I understand that unless I revoke the authorization earlier, this authorization will automatically expire _____ (insert time period) from the date this authorization is signed.

4. Redisclosure. I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be redisclosed by the receiving party.

5. Refusal to Sign. I understand that I may refuse to sign this Authorization and that the practice will not condition treatment on whether I sign this Authorization.

6. Certification. I certify that I am *(check whichever applies)*:

☐ the patient, and the identification that I have provided is true and correct.

☐ the patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of: _____.

Signed this _____ day of _____, 20___.

Signature: _____
Print name: _____
Address: _____
_____
Phone No: _____

Witness: _____
Print Name: _____
Date: _____