

**Authorization for release/use of
Pictures or X-Rays**

Name of office: Aliso Viejo Dental

Your photos and x-rays are part of your diagnostic and clinical records and are considered to be protected health information under federal HIPAA Privacy Laws.

Some cases that present exceptional results, particularly remarkable smiles, or interesting situations may be utilized for demonstration, education or advertising to potential and existing Patients in our office either in social media, on digital media and on our website and in print. In some instances, you may be recognizable in some of these images.

By initialing and signing this form, you are authorizing us and releasing us from any liability resulting from the use/release of such images. Your authorization and release to use images will in no way affect the quality of your results in our office. We do our best to provide exceptional dentistry to all our Patients.

I authorize the use of my images where my face is identifiable

I authorize the use of my images where only my teeth are identifiable

I authorize the use of my radiographs

The purpose of this request to release and/or disclose the PHI described above is for personal reasons. I understand that I have the right to revoke this Authorization in writing, at any time by notifying the office above. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation. I also understand information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by this rule.

I understand that my health care provider cannot condition treatment on whether I sign this Authorization.

Name _____

Signature of Patient

Date