John A. Carollo, DMD

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PATIENT AUTHORIZATION FORM

I hereby authorize Dr. Carollo to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information listed below to be used or disclosed:

Dental Images _____

Children's Polaroid Photos _____

Other: _____

Person or entity requesting the information and authorized to make the requested use or disclosure:
_____***Dr. Carollo***_____

Recipient of the information: _____***Dr. Carollo***_____

This information is being requested for the following purposes(s):

- ***Dental Images as a record of my care and they may be used for educational purposes in demonstrations, lectures, professional journals, and/or office marketing. My name or other identifying information will be kept confidential.***
- ***Children's Polaroid Photos are use for in office hallway photography board only***
- ***Other*** _____
- _____

This authorization shall remain in effect from the date signed below

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

Patient Name:_____

Signature:_____

Date:_____

Relationship to Patient:_____
(If signed by personal representative of Patient):