

Authorization for Use and Disclosure of Protected Health Information

Name of Practice: **SPARTA OPTOMETRY, PC** (the “Practice”)

Authorization:

By my signature below, I affirm, as a patient of the Practice named above OR as the parent or legal guardian of a minor child that is a patient of the Practice named above (the “**Patient**”), that I authorize the Practice: (i) to capture photographic or video images of the Patient (the “**Images**”); (ii) to reproduce, use, and disclose the Images, with or without the Patient’s name; (iii) to publicize the fact that dental services were provided to the Patient; (iv) to reproduce and publish any testimonials the Patient provides regarding the Practice (collectively referred to herein as the “**Information**”); and (v) to secure copyright registration for any materials that incorporate the Information, at the election and sole expense of the Practice. The authorization is given to the Practice listed above, for disclosures to any persons, without limitation, who may view the Information in printed or digital form in promotional materials including social media or Internet sites.

Purpose:

The purpose of this authorization is to permit the Information, including Images, to be used for marketing of the Practice, and I explicitly consent to the use of Information for advertising and marketing activities to promote the Practice. I acknowledge and agree that no compensation will be provided for the use of the Information.

Expiration and Revocability:

If Patient is signing on his or her own behalf, this authorization expires when the Patient informs the Practice that he or she is no longer a patient of the Practice. If Patient is signing on behalf of a minor child, this authorization expires when the Patient reaches the age of majority, but the authorization remains valid for protected health information already used or disclosed until revoked by the Patient who has attained majority. However, I understand that protected health information already used or disclosed prior to any revocation may no longer be protected. I understand that I may revoke this authorization at any time by notifying the Practice by Certified Mail, return receipt requested, but that revocation will only affect uses and disclosures initiated after the date notice is received by the Practice. Upon receipt of the notice of revocation, the Practice will make reasonable efforts to remove protected health information from social media platforms over which it has control, but cannot guarantee removal from all sites. I understand and explicitly acknowledge that the Internet allows for wide sharing and forwarding of information, and that the Practice cannot control all re-disclosure of information.

No Effect on Treatment:

This authorization is voluntary. I understand that the Practice cannot condition treatment of the Patient on whether I sign this Authorization, and that my decision not to sign will not influence or affect the Patient’s treatment in any way.

Name of Patient (printed): _____
(Self or minor child)

Date of Birth of Patient: _____

**Signature of Patient OR
Parent/Legal Guardian** (if signing for minor): _____

Printed Name of Parent or Guardian: _____
(if signing on behalf of minor child)

Date of Signature: _____