Kellerman Dental

HIPAA CONSENT FORM

Authorization to release medical information to other individuals

Date: ____

Patient's Name: ______________________________________

Patient's Date of Birth: _________________________________

I hereby authorize **Kellerman Dental** to release my Protected Health Information either verbally or in printed form to the following persons:

Name	Relationship to patient
Name	Relationship to patient
Name	Relationship to patient
Name	Relationship to patient

☐ I also authorize **Kellerman Dental** to release the Protected Health Information to anyone that may bring the patient in for their visit who may not be listed above.

Patient/ Guardian Signature **Date Signed**

PHOTO / VIDEO RELEASE

I hereby grant **Kellerman Dental** permission to use diagnostic photographs and records in publications and/or on the office website, blog, Facebook and You Tube for informational or marketing reasons.

I understand that I have the right to request, in writing, removal of the photo and/or video from the website within 30 working days of receipt of the request by **Kellerman Dental**. I understand that this photo and/or video may be used in office publications or on a website designed to promote dental services as well as offer information and resources. By signing below, I acknowledge my understanding of the above and grant my permission for use of the photograph(s) and/or video(s).

☐ **I choose to not release any photograph(s) or video(s) at this time**.

Patient/ Guardian Signature **Date Signed**

This authorization will remain in effect for one year from the above date.