POWER ORTHODONTICS

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SOCIAL MEDIA AUTHORIZATION FORM
HIPAA RELEASE OF INFORMATION

I hereby authorize POWER ORTHODONTICS, to publish the following personal information: **Dental Photographs** On the following social media platforms: Business Facebook pages, Office Website and case presentations to other Dental Professionals.

The following information will **NOT** be disclosed: The patient's name, information relating to claims, payments, insurance information, contact information, medical history, and contractual financial information.

I understand that any dental photographs released via the social media platform (s) above may be subject to re-disclosure by such social media platform (s) and may no longer be protected by applicable Federal and State privacy laws.

This authorization is valid from the date of my/my representative's signature below

I understand that I have a right to revoke this authorization by providing written notice to POWER ORTHODONTICS. However, this authorization may not be revoked if, Power Orthodontics have taken action on this authorization prior to receiving my written notice. I also understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

☐ Facebook ☐ Website ☐ Case Presentation

Name of Patient:_____

Signature of Responsible Party:_____

Date: _____