BARRINEAU D.D.S. P.A.
Family and Cosmetic Dentistry

MARKETING AUTHORIZATION
FOR USE OR DISCLOSURE OF HEALTH INFORMATION

_____ _____
Print Name of Patient Date of Birth

If patient is a minor, authority of representative to sign on behalf of the patient:
❒ Parent ❒ Legal Guardian ❒ Court Order ❒ Other: _____

Patient Authorization: I authorize Barrineau, DDS, PA., Family and Cosmetic Dentistry to use or disclose the following information (check all that apply):

❒ Pre and Post treatment photos

❒ Written reviews such as those posted on social media or Google

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This authorization ends when notified in writing by the patient.

Patient Rights: I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. To revoke this authorization, I must do so in writing and send it to the practice.

I understand that uses and disclosures already made based upon my original permission cannot be taken back. And that it is possible that information disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the Privacy Standards.

I understand that I will not receive any remuneration from Barrineau, DDS, PA., Family and Cosmetic Dentistry.

I understand that my dental treatment may not be conditioned upon my signing this authorization and that I have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

_____ _____

Signature of Patient/Authorized Representative Date