AUTHORIZATION FOR USE AND RELEASE OF PERIODONTAL INFORMATION FOR RESEARCH, EDUCATION, AND PROMOTIONAL PURPOSES

_____
Periodontist's Name

_____
Periodontist's Address City State Zip

Patient's full name at the time of treatment: _____

Date of birth: ___ /___ /_____ Social Security Number: ____-___-_____

I authorize the use and disclosure of any or all of my periodontal records, including but not limited to my name, photos, records, slides, x-rays, and other viewings of my care and treatment before and after completion of procedures for research, education, and promotional purposes.

1. I understand that I may revoke this authorization at any time, but revocation will not apply to information that has already been released. Revocations should be sent to the periodontist at the address as noted on top of this form.
2. I understand that I may refuse to sign this authorization and that the periodontist may not condition my treatment on whether I provide this authorization.
3. I understand that this authorization will expire one year after the date of my death.
4. I understand that no recipient of my periodontal information is covered by the federal privacy regulations that protect the privacy of healthcare information, and that after its release, my information will be subject only to the recipient's privacy policies and not to federal law.
5. I understand that I may receive a copy of this authorization by submitting a request to the periodontist at the address noted on the top of this form.

_____ _____
Signature of Patient or Authorized Person Date

_____
Relationship to Patient/Reason Patient is Unable to Sign