PHOENIXVILLE DENTAL

HIPAA Authorization

for use and disclosure of protected health information
for marketing, public relations and external Communications

I hereby authorize The Omene Dental Group LLC, d/b/a Phoenixville Dental, and its owners, employees, affiliates licensees and assigns (collectively, "**Phoenixville Dental**") to use, disclose and release my Health Information as defined below, for the purposes set forth in this Authorization.

By **initialing** below, I specifically authorize Phoenixville Dental to use, disclose and release the following **Health Information**" about me:

_____ (initial) My appearance, image, name, diagnosis and medical/dental condition; pictures, images and video relating to the treatments and services that I receive and the results of such treatments and services; and related medical and dental records.

_____ (initial) The following information: _____

_____

_____

The Health Information, initialed above, may be used for promotional, advertising, marketing, educational and informational purposes, which is intended by Phoenixville Dental to generate additional business for its dental practice, through local, state and national media broadcasting and publication outlets, including, without limitation, any and all websites, portfolios, catalogs, training materials, advertisements, brochures, photographs, posters, videos, commercials, displays, newsletters, news or editorial coverage or any other media now or hereafter known or devised, with and without my name, both singly and in conjunction with other persons.

I understand that the terms of this Authorization are governed by the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations, as may be amended from time to time ("HIPAA"). I understand that I have the right to revoke this Authorization, but such revocation shall not apply to the extent that Phoenixville Dental has already relied on this Authorization. I further understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this Authorization is set forth in Phoenixville Dental's Notice of Privacy Practices. I understand that any revocation must be in writing and include my name, address, telephone number, date of this Authorization and my signature, and that I must send it to: *The Omene Dental Group LLC, d/b/a Phoenixville Dental, 883 Valley Forge Road, Phoenixville PA 19460;* Attn: Privacy Officer

I understand that I am not required to sign this Authorization as a condition for me to receive treatment from or with Phoenixville Dental. I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure once it is used for the intended purpose and, in that case, will no longer be protected by HIPAA. This Authorization shall expire after one year following the date of its execution. I hereby acknowledge receipt of a copy of this Authorization.

_____/_____/_____ Date

_____ Signature of Individual (or Legal Representative)

_____ Legal Rep's Authority

_____ Print Name of Individual (patient)

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