Ragan ORTHODONTICS

PRIVACY AUTHORIZATION

This Authorization is required by the privacy regulations recently promulgated by the United States Department of Health and Human Services.

You or your child's protected health information, including photographs, x-rays, study models can be used or disclosed for the purpose of:

□ Lectures/presentations;
□ Publications;
□ Research; and or
□ Practice Marketing

The information will be disclosed on an as needed basis by our office.

This Authorization will expire on _____, 20___.

You have the right to revoke this Authorization at any time in writing. However, your revocation will not be effective to the extent that this Authorization has been relied on.

The information used or disclosed per this Authorization may be subject to re-disclosure by the recipient(s), and thus, no longer protected by the privacy rules.

_____
Patient or Parent's Signature

_____
Print Name

_____
Date