

**CONSENT AND AUTHORIZATION FOR PHOTOGRAPHY**

**CONSENT TO PHOTOGRAPH/RECORD/INTERVIEW AND AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

Alfi Oral, Dental Implant & Facial Surgery is pleased when patients are willing to share their stories, experiences, and information about their treatment received and allow the use of this information for communication and education. To ensure Alfi Oral, Dental Implant & Facial Surgery is acting in accordance with your wishes, and using your personal information with your authorization, we ask that you complete this form.

I give Alfi Oral, Dental Implant & Facial Surgery permission and consent to record my image or voice via photographs, films, audio, video, other recordings, and/or interview me and share details of my treatment and experience which may include my name, diagnosis, medical condition, and details of health care as a patient, produced by or on behalf of Alfi Oral, Dental Implant & Facial Surgery. I authorize the use or disclosure of this protected health information for the purpose of:

- Publicity, Advertising, Marketing .....  Yes  No  
 (including but not limited to print, internet, social media, radio, television, events, publications, news)
- Medical Education .....  Yes  No  
 (including, but not limited to conferences, graduate education, continuing medical education, medical journals, professional trade organizations)

Each box checked "Yes" is permitted use and disclosure under this agreement ("Permitted Uses and Disclosures").

I agree to authorize the distribution and publication of the photographs, films, audio, video, and other recordings via print or electronic means including but not limited to Alfi Oral, Dental Implant & Facial Surgery's website, Alfi Oral, Dental Implant & Facial Surgery's publications via print, newspaper, magazines, television, radio, social media, advertisements, and other permitted uses and disclosures. I further authorize any such photographs, films, audio, video, or other recordings to be edited and incorporated into any compilation or copied work as considered necessary or appropriate by Alfi Oral, Dental Implant & Facial Surgery. I waive any right to inspect or approve my voice or images in these works. I understand that my photographs, films, audio, and video may exist forever in either a recorded, printed, and/or electronic version or other version as may develop over time and that once it is published or disclosed in any form, it may continue to be used. Information pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by state and federal privacy laws.

This authorization does not expire and continues unless revoked. I understand that I may stop the photography, filming, audio, video, or other recording at any time during the recording process. If I change my mind about the use of disclosure, I may revoke or withdraw this authorization at any time unless the use or disclosure process has already occurred. I may withdraw this authorization by contacting Alfi Oral Surgery in writing.

I further understand that this consent and authorization is optional and I am not required to sign this for medical treatment or payment. I know that I am not entitled to any compensation as a result of any use of information and photographic, film, audio, or video material. I understand I will disclose my information to the affiliated representatives as I choose and may be identified in any use of the above materials.

I hold Alfi Oral, Dental Implant & Facial Surgery and its employees, affiliates, and representatives harmless from any and all liability, claims, and damages arising from this interview and any associated audio, video, or other print or recording used or disclosed as a result. A scan, fax, or photocopy of this form is as valid as the original. By signing below, I acknowledge that I have read and understand the terms of this authorization and knowingly and voluntarily authorize Alfi Oral, Dental Implant & Facial Surgery to use and disclose my protected health information as described above.

Printed Name of Patient/Individual Providing Consent \_\_\_\_\_

Date of Birth \_\_\_\_\_

Printed Name of Qualified Personal Representative (if applicable) \_\_\_\_\_

Authority to Act on Behalf of the Patient/Individual Providing Consent \_\_\_\_\_

\_\_\_\_\_  
 Signature of Patient or Qualified Personal Representative

\_\_\_\_\_  
 Date

\*Note: A copy of this signed form must be provided to the patient or patient's representative.