



LEHIGH VALLEY SMILE DESIGNS

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Patient Authorization For Marketing Communications

To Our Patients:

From time to time, our dental practice would like to tell patients about products and services that we think may be of interest to them. When we give patients promotional gifts of nominal value, or recommend products or services in face-to-face communications, we do not require the patient's written authorization. However, we do require a patient's written authorization before sending other kinds of marketing communications if our dental practice receives financial remuneration for sending the communication.

If you would like to receive information about products and services from our dental practice, please complete and sign the authorization form below and return it to us at your convenience.

Authorization

Patient Name: _____

Patient's Date of Birth: _____

I hereby authorize the dental practice to use my name and address and other information about my dental health to provide marketing communications to me. I also authorize the dental practice to disclose such information to a business associate for purposes of sending marketing communications to me.

I understand that the dental practice receives financial remuneration for making marketing communications.

I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient, and may no longer be protected by HIPAA Privacy regulations.

I understand that I may revoke this authorization at any time by following the directions in the Notice of Privacy Practices. I understand that my revocation must be specific and in writing. If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

This authorization expires on the following date, or when the following event occurs:

Event description: _____

Print Name of Signer: _____ Relationship to Patient: _____

Signature: _____ Date: _____

For Office Use Only

Copy of signed authorization provided to the individual:

Date: _____

Initials: _____

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Your Best Look Starts With A Great Smile!

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