HIPAA AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient's Name:_____DOB:_____

Address:_____

Email:_____Phone:_____

I hereby authorize Oral Arts Laboratory, Inc. to disclose my protected health information in accordance with this authorization.

The personal health information to be disclosed includes, but is not limited to, pictures whether taken separately or derived from electronic means (ie. photo's received from dentist, patient, or directly taken in lab). I have volunteered to have my personal health information used and disclosed as set forth in this authorization, primarily on social media (ie. "before and after photos" on Oral Arts' Facebook, Instagram, and Twitter accounts).

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the Oral Arts Marketing Department at 2700 Memorial Parkway SW, Huntsville, AL 35801, or by email at marketing@oralartsdental.com. If I revoke this authorization, my revocation will not affect any actions taken by the dental lab before receiving my written revocation.

I understand that I may request to inspect and/or copy the information to be disclosed.

I understand that this authorization is voluntary. I understand that I do not need to sign this form in order to ensure health care treatment, including restoration fabrication, payment, enrollment in my health plan, or eligibility for benefits. I also understand that if I have any questions regarding the use or disclosure of my health information, I may contact the Oral Arts Marketing Department by phone at (256)533-6670, ext. 7154, by mail, or by email at marketing@oralartsdental.com.

Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by the federal regulations protecting privacy of an individual's health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Regulations") and other applicable federal and state law. I am also aware and consent to the continued use of my personal health information once it is published or used or disclosed in any form that it will exist forever in either a recorded version and/or a printed or electronic or other version as may develop over time. I also understand that Oral Arts Laboratory, Inc. will retain copies of any such electronic or printed versions and shall potentially retain these versions forever and that any revocation of this authorization will only extend to the versions of the information within Oral Arts Laboratory, Inc.'s control. Photocopies and facsimile copies of this Authorization shall be deemed to be originals.

_____ _____

Patient or Legal Representative Date

_____ _____

Representative's authority to act on behalf of individual Witness