

PATIENT AUTHORIZATION FOR MARKETING – ALL PRODUCTS AND SERVICES

To our Patients:

From time to time, our 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 communication, 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 practice receives financial remuneration for sending the communications.

If you would like to receive information about products and services from our practice, please complete and sign the authorization form below.

Authorization

Patient Date of Birth: _____ Patient Chart No: _____

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

I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA Privacy regulations. 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 practice's Privacy Official at the doctor's address shown above.

I understand that if I revoke this authorization, my revocation will not affect any actions taken by the 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: _____