Patient Photo Release Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.

This release is strictly designated to give permission to Olmedo I. Villavicencio DDS, to use my digital patient photo series. I will allow these photos to be shared with other professionals and patients strictly in an educational setting. Dr. Villavicencio will have permission to use these photos in the manner described above unless I request him to no longer use them. A written request form is available to do so. I understand that by allowing Dr. Villavicencio to use my photos, he is able to share "before and after" images to educate and explain procedures and possible results of treatment. I understand that I have the option to decline this request, and am not obligated in any way to provide permission to use these photos.

I will allow Dr. Olmedo I. Villavicencio DDS to share my digital patient photos with other patients and /or professionals in an educational setting.

_____Full Photo Series _____Close up Photos Only (no Face)

Patient Name_____

Signature_____

Date_____

I am requesting that my digital patient photos not be shared with other professionals or patients.

Patient Name_____

Signature_____

Date_____