MARKETING RELEASE FORM

Date:_____

I, _____(name of patient or patient's representative) want Justin Family Dentistry to communicate with me via e-mail, phone, text, mail or other media about products or services that pertain to my conditions or that can contribute to matters related to my health and/or my medical treatment. I understand my Protected Health Information may be referenced to determine that I may be likely candidate for products or services that my dental health practitioner may share with me.

Justin Family Dentistry may communicate with me about my oral health, treatment, appointments, and post-operative follow-ups by mail, e-mail, text or by phone to the contact information on file. It is my responsibility to ensure all my contact information is up-to-date.

I understand that communication between Justin Family Dentistry and I may not be encrypted and my information could be intercepted by unauthorized persons.

Justin Family Dentistry will not be responsible for any unauthorized interceptions. However, we will make reasonable measures to ensure proper delivery or notification of our patient's information. Examples include, but are not limited to, post-operative phone calls and appointment reminders.

This consent remains in effect until expressly revoked (in writing).

Name:_____
(Print Patient's Name or Name of Patient's Representative)

Signature:_____
(Signature of Patient or Patient's Representative)

Witnessed by:_____
(Print Name)

Signature:_____
(Signature of Witness)

HIPPA MARKETING RELEASE FORM