**Dental Treatment Consent**

The undersigned hereby authorizes Dr. Victor Gittleman and employees to take x-rays, study models, photographs or any other diagnostic aides deemed appropriate by the Doctor.
This is important to obtain a thorough diagnosis of the patient's dental needs.
I also authorize Dr. Victor Gittleman to perform any and all forms of treatment, medication and therapy that may be indicated in connection with ____________________________.
**(Name of Patient)**

I further authorize and consent that Dr. Victor Gittleman choose and employ such assistance as fit to provide treatment as needed. I understand the use of anesthetic agents embodies a certain risk.

| ______________________________ | ______________ | ______________________________ | ______________ |
|---|---|---|---|
| **Patient Signature or Account Responsible Party Over 18 years** | **Date** | **Patient Name Please Print** | **Date** |

**Authorization For Use Or Disclosure Of Patient Photographic and / or Video Images**

**Authorization:**
I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by Morristown Cosmetic Dentistry. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and my no longer be protected by HIPAA privacy regulations.

**Purpose:**
The photographic/video images, and/or testimonial will be used for: *Social Media and/or Advertising*

**Revocability:**
I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

**No Treatment Conditions:**
I understand that the practice cannot condition treatment on whether or not I sign this authorization.

**If desired, copy provided:**
☐ "Yes, I would like a copy of this form."
(initialed by team member, copy provided by __________)

| ______________________________ | ______________ | ______________________________ | ______________ |
|---|---|---|---|
| **Patient Signature or Account Responsible Party Over 18 years** | **Date** | **Patient Name Please Print** | **Date** |

**HIPAA Privacy Consent**

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights regarding my protected health information. I understand that this information can and will be used for;

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from Third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notices of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its notice organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment. Payment of health care operation. I also understand you are not required to agree to my requested restrictions. If you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time. Except to the event that you have taken action relying on this consent.

| ______________________________ | ______________ | ______________________________ | ______________ |
|---|---|---|---|
| **Patient Signature or Account Responsible Party Over 18 years** | **Date** | **Patient Name Please Print** | **Date** |