Patient Authorization and Release Form

I consent and agree that the photograph(s), or dental image(s) made of me on _____ by _____(dentist's name) may be distributed to and used by the Academy of Osseointegration (AO)/Osseointegration Foundation(OF) or its licensees or assigns for the purposes of public information, public education, training, and for any other purposes AO/OF deems appropriate to inform the dental profession or the general public about the field of implant therapy or tissue replacement therapy.

I have been advised that neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photograph(s) may portray features that may make my identity recognizable.

I grant this consent as a voluntary contribution in the interest of public education. I understand that such photograph(s) or medical image(s) shall become the property of the AO/OF and may be shown, published, printed, broadcast or otherwise disseminated in any print, visual or electronic media, specifically including, but not limited to CD Roms, Internet still/video postings, newspapers, television, dental journals and textbooks. I release all discharge from Dr. _____ , the AO/OF, and all parties acting under their license and authority from all rights that I may have in the photograph(s), or dental image(s), including any claim for payment in connection with their distribution or publication.

I understand that, to the extent permitted by law, I have the right to inspect and copy the photograph(s), or medical image(s) that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. If I do not revoke this authorization, it will expire ten years from the date of its execution.

I understand the photograph(s), or medical image(s) disclosed, or some portion thereof, may be protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I further understand that because AO/OF is not receiving the photograph(s) or medical image(s) in the capacity of a health care provider or health plan covered by HIPAA, the photograph(s) or medical image(s) may be redisclosed and may not longer be protected by HIPAA.

By signing this form, I certify that I have read the above authorization and release and fully understand its terms.

Patient Name: _____

Address: _____

City, State, Zip: _____

Signature: _____ Date: _____

If patient is a minor:

Guardian Name: _____

Address: _____

City, State, Zip: _____

Signature: _____ Date: _____

Please return with OF Charitable Grant application to:
Osseointegration Foundation
Attn: Kim Scroggs
85 W. Algonquin Road, Suite 550
Arlington Heights, IL 60005