ChauLong T Nguyen Dental Corporation/Menlo Park Dental Excellence
ChauLong T Nguyen, DDS, MAGD, LLSR, AFAAID
905 Middlefield Rd, STE B, Palo Alto, CA 94301
Office #: (650) 838-0260 Email: chaulongdds@protonmail.com

Patient Photograph Authorization Form

CONSENT TO THE USE OF THESE IMAGES (please circle "yes" or "no")

1) Do you give consent for ChauLong Nguyen Dental Corporation to take photographs, slides, and/or videotape of your jaw and teeth? YES NO

2) Do you understand that these images will become part of the patient record? YES NO

3) Do you understand that these images will become part of the patient's dental insurance record? YES NO

4) Do you understand that some of these images may be used for laboratories for fabrication of crowns, veneers bridges or dentures? YES NO

5) Do you consent to the use of these images in professional articles and presentations? YES NO

6) Do you consent to the use of these images within the dental practice to be seen only by individuals who walk into the practice and lab? YES NO

7) Do you consent to the use of these images to promote the dental practice through various media, including but not limited to advertising, brochures and the practice website, Yelp, Google and Facebook? YES NO

By consenting to the use of these images and/or photographs as described above, I do not expect compensation, financial or otherwise from ChauLong Nguyen Dental Corporation (Menlo Park Dental Excellence). I hereby release and discharge ChauLong Nguyen Dental Corporation (Menlo Park Dental Excellence) from all claims and demands arising out of or in connection with the use of my name, photograph, or other information provided by me, including all claims for libel and invasion of privacy.

I understand the receiving party may not further disclose this health information without first obtaining a new written authorization from me. I understand this authorization may be canceled or modified at any time upon provision of a written notice to this dental practice. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. Unless revoked by me in a written form, this authorization expires 10 years from the date I sign below. I understand that I may have a copy of this authorization.

_____ _____

Patient's (or Representative's) Signature **Date**

ChauLong T Nguyen Dental Corporation
Menlo Park Dental Excellence
ChauLong T Nguyen, DDS, MAGD, LLSR, AFAAID
881 Fremont Ave, Ste A4 Los Altos, CA 94024
Office #: (650) 838-0260 Email: chaulongdds@protonmail.com

Consent for Use and Disclosures of Health Information

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practice: You have the right to read our Notice of Privacy Practice before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of the important matter about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it completely before signing this Consent.

We reserve the right to change our privacy policies as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to ChauLong T. Nguyen, DDS. Please understand that the revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I acknowledge that I have received from Menlo Park Dental Excellence a copy of the Dental Board of California's *"The Facts About Fillings*."

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

_____ _____

Patient's (Patient Representative) Signature **Date**