RELEASE FORM

Authorization and Release of information

I certify that I have read and understand the attached information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/ or health practitioners. I authorize and request my insurance company to pay directly to the dentist of dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ Date _____/_____/_____
Patient Signature

HIPAA Patient Acknowledgement

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions please feel free to ask one of our staff members. If not we would appreciate very much your acknowledging you have reviewed our policy by signing this form.

X_____ Date _____/_____/_____
Patient Signature

PHOTO RELEASE

In consideration of my engagement as a model for educational or promotional purposes, I hereby grant to J. Paul Keelan, D.M.D. the authority and permission to publish and re-publish photographic portraits or pictures of me, in whole or in part, without restriction and in conjunction with my own or a fictitious name. I understand that the portraits may be used in any and all media now or hereafter known for educational, illustration, editorial, or advertising purposes.

I waive any right that I may have to inspect or approve the finished product or products and the educational or advertising copy used in connection therewith or the use to which it may be applied.

I hereby warrant that I am of full age and have the right to contract in my own name. I have read the above authorization, release, and agreement, prior to its execution, and I am fully familiar with the contents thereof. This release shall be binding upon me and my heirs, legal representatives, and assigns.

X_____ Date _____/_____/_____
Patient Signature