**Contemporary Implantology, Inc.**

## Authorization Form for Use or Disclosure of Patient Information, for Educational Purposes

Patient Name:_____ Patient Date of Birth:_____

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

The patient information to be used or disclosed shall be **photographs, radiographs and/or CT Scans**. The purpose(s) of this use or disclosure shall be for **educational purposes**. I authorize, **Dr. S. Yusuf Shere and his Study Group(s), who are General Dentists and/or Dental Specialists and Dental Company Representatives** to make this use or disclosure of my patient information for educational purposes.

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official at *Contemporary Implantology, Inc. 902 Frostwood Dr. Suite 203, Houston, TX 77024*. My revocation will not affect any actions taken by the dental practice before receiving my written revocation.

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a dental plan, or eligibility for benefits.

This authorization expires when the following event occurs: *The end of the research study.*

_____ _____

**Signature of Patient or Patient's Representative** **Date**

*If Patient Representative:* Print Name_____

Signature:_____ Relationship to Patient:_____

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## Agreement to Receive Electronic Communication

Patient Name:_____ Patient Date of Birth:_____

I agree that the dental practice may communicate with me electronically at the email address listed below.

**I am aware that there is some level of risk that third parties might be able to read unencrypted emails.**

I am responsible for providing the dental practice any updates to my email address. I can withdraw my consent to electronic communications by calling **713-464-2792**.

**EMAIL ADDRESS – *please print clearly:***

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**Signature of Patient or Patient's Representative** **Date**