HIPAA Authorization to Use and Disclose PHI for Marketing Purposes

1. I authorize **Highway K Dental Care** and its-Business Associates and Subcontractor Business Associates (collectively, "We" or "Us") to use and disclose my health information ("Health Information") for the purpose of delivering marketing messages to me and requesting feedback about my patient experiences, and suggestions as to how We can improve email and/or text message offerings, to the email address and/or mobile telephone number previously provided to Us (the "Authorized Purposes"). I understand that the frequency of these messages may vary.
2. I understand that my Health Information may also include information provided by me or by my health plan, or other healthcare providers, and also other publicly available information. I understand that my Health Information may be considered "Protected Health Information" ("PHI") as defined under the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations (collectively, "HIPAA").
3. I authorize the use and disclosure of any Health Information or PHI by Us for this purpose.
4. I understand that communications transmitted via unencrypted email, text message or over an open network may be inherently unsecure, and there is no assurance of confidentiality for information communicated in this manner. I also understand that emails and text messages have inherent privacy risks, especially when access to my computer or mobile device is not password protected.
5. **I acknowledge that my signing of this Authorization is voluntary. I understand that I am not required to sign this Authorization, and my decision to sign or not sign will have no effect on my treatment, enrollment or eligibility or payment for benefits.**
6. I understand that, once my Health Information or PHI has been disclosed pursuant to this Authorization, federal and state privacy laws may no longer protect the information from further disclosure. However, we agree to protect your Health Information and PHI by using and disclosing it only for the Authorized Purposes or as required by law or regulation.
7. I understand that the Authorized Purposes described above may also involve direct or indirect financial remuneration from a third party in connection with the use or disclosure of my Health Information.
8. I understand that I may revoke this Authorization at any time by notifying Heartland Dental's Privacy Officer in writing at 1200 Network Center Drive, Effingham, IL 62401; for text messages, by replying "STOP"; or for email messages, by following the instructions in the email to unsubscribe. Standard message and data rates may apply. I also understand that the revocation will not be effective until Heartland Dental receives it but will not affect any actions taken by Heartland Dental in reliance on this Authorization prior to receiving written notice of the revocation.
9. I understand that I have the right to receive a copy of this Authorization for my records.
10. This Authorization is valid from the date indicated below until the sooner of the date that Heartland Dental receives written revocation, as described in paragraph 7, above, one year after the below date, or as otherwise limited by applicable law.

I have read this Authorization carefully prior to signing it, I understand its contents, and I have freely signed this Authorization.

_____ _____

Signature (Patient/Personal Representative*) **Date**

**Personal Representative: Please attach documentation validating your authority.*

Printed Name: _____