

MICHAEL A. KELLER, D.D.S., P.C.

**AUTHORIZATION FOR USE AND DISCLOSURE OF
HEALTH INFORMATION FOR MARKETING PURPOSES:**

PURPOSE OF AUTHORIZATION: By signing this form, you will give our office authorization to use your child's/children's protected health information, (specifically if your child/children have no cavities upon their routine preventive visits) for our marketing purposes described below.

AREAS OF MARKETING: By signing this authorization the parent gives permission for their child/children to sign their name to our in-office "NO SUGAR BUG CLUB" bulletin board when they have received a "no cavity" check-up on routine visits. Also by signing this authorization the parent allows our office to use their child's/children's name in the monthly publication of the Over the Mountain Journal specifically for the "NO SUGAR BUG CLUB" and ,if appropriate, for the purpose of our monthly in-office marketing games and contest. Also by signing this the parent is authorizing their child's/children's picture to be used for occasionally advertising and marketing.

RIGHT TO REVOKE: You have the right to revoke the Authorization at any time by giving us written notice of your revocation submitted to the contact person listed below. Please understand that based on the time of the month that the revocation is given we may or may not be able to cancel your child's/children's name or picture in any up-coming publication. However, all efforts will be made to fulfill your requests. Please also understand that revocation will have no bearing on the treatment and care of your child/children in our office.

SIGNATURE: I, _____

Give authorization for my child/children : _____

To participate in all the marketing activities described in this form for twenty-four (24) months from this date: _____

Contact Person: Melinda Sullivan for the office of Dr. Michael Keller
Telephone: (205) 870-7110
Address: 2045 Medical Center Drive Birmingham, Al. 35209