HIPAA AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION – MEDIA

Patient Name:_____

Patient DOB: _____

I hereby authorize _____ and its agents and employees (the "Practice") to use and disclose the information described below for the purposes of creating press releases, news stories, photographs or video clips, website and/or publications, as well as stand-alone pictures/graphics in which I may appear and/or be heard, for use in internal publications and disclosure to external media.

The information about me may include my: name, age, photographs, place of residence, treatment, and information about my life. The Practice will not receive any direct or indirect payment in exchange for the release of this information about me.

I understand that the Practice may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. I understand any information used or disclosed pursuant to this Authorization may be subject to redisclosure and no longer protected by the Federal privacy regulations.

I understand I have the right to revoke this Authorization, in writing, at any time by sending such written notification to the attention of _____ at the Practice. I understand that my revocation will not be effective to the extent that the Practice has already taken action in reliance on this Authorization.

I hereby release, discharge, and agree to hold the Practice harmless from any liability that may arise from the release of information authorized above.

This Authorization shall expire 10 years from date of signature.

Date: _____ _____

Signature of Patient or Personal Representative

_____

Name (Please Print)

If the patient is a minor or has a personal representative, I represent that I am the legal parent, guardian, or personal representative of the Patient named above, and I am not prohibited by Court Order from releasing access to the requested information.

PATIENT CONSENT AND RELEASE AGREEMENT

Patient Name:_____

I hereby grant to _____ (the "Practice") and its affiliated entities, licensees, successors, and assigns (collectively, the "Licensed Parties") a perpetual right and license to use, publish, and broadcast, as well as to copyright, my testimonial statement, voice, picture, name, and likeness in any and all media and types of advertising and promotion for the Licensed Parties and their products and services (collectively, the "Licensed Use").

I understand that I will not have any right to compensation in connection with the Licensed Use. I hereby release the Licensed Parties from any and all claims arising out of the Licensed Use, including, without limitation, any claims based on libel, slander, or the rights of publicity, privacy, or personality. I hereby waive any right to pre-approve any Licensed Use.

I acknowledge that this permission authorizes the Licensed Parties to post my testimonial statement, voice, picture, name, and likeness on third party social media web sites, which may require Licensed Parties to grant the owners and users of such sites a broad license to use such materials for any purpose without notice to or approval from me.

I understand that I have the right to revoke this Consent and Release by delivering written revocation to the Practice; provided, however, that this will not impose any obligation upon the Licensed Parties to recall or destroy any materials already used, published, or disclosed.

This Consent and Release does not in any way conflict with any existing commitment on my part.

Date: _____ _____

Signature of Patient or Personal Representative

_____

Name (Please Print)

If the patient is a minor or has a personal representative, I represent that I am the legal parent, guardian, or personal representative of the Patient named above.