AUTHORIZATION FOR USE OR DISCLOSURE OF PHOTOGRAPHS/IMAGES/FILMS/VIDEOS

_____ may disclose protected health information in
(Covered entity)
the form of photographs, digital images, films, and/or videos from the records of the following patient:

_____
(Patient name)

_____
(Date of birth)

The reason(s) for this authorization (check all that apply):

☐ Education of other patients or physicians.

☐ The healthcare provider requests the information for marketing purposes.

☐ The healthcare provider will get something of value for providing health information for marketing purposes.

☐ Other (specify each purpose) _____

Initial one:

_____ I agree and authorize the above-mentioned healthcare provider to place my photos, images, films, or videos on the provider's professional website.

_____ **I DO NOT** authorize the use of these photos, images, films, or videos on any website.

Patient's Initials

_____ I understand that the images will not be identified by name but that such photographs, videotapes, computer images, and/or internet images may reveal my identity. I accept this loss of anonymity.

_____ I understand that I have the right to revoke this authorization, ***in writing***, at any time by sending a written notification to the practice at _____ _____ (Office mailing address).

_____ I understand that a revocation is not effective to the extent that my healthcare provider has already disclosed the health information.

_____ I understand that I do not have to sign this authorization in order to get healthcare benefits (treatment, payment, or enrollment).

_____ I understand that information released by this authorization may be disclosed by the recipient and may no longer be protected by federal and state law.

_____ I further understand that photographs placed on the internet become part of the public domain and may be modified or used for unintended or unanticipated purposes, including for commercial gain.

_____ I understand this authorization ends:
☐ on (date) _____
☐ when the following event occurs _____

SIGNATURES

Patient or Legal Representative Signature/Date/Time

Print Patient's or Legal Representative's Name

Legal Representative's Relationship to Patient

Witness Signature/Date/Time

Print Witness's Name

Healthcare Provider Signature/Date/Time