Authorization For Use Or Disclosure Of Patient Photographic and/or Video Images

Authorization:
I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by the practice listed below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Purpose:
The photographic/video images, and/or testimonial will be used for: *Social Media and/or Advertising*

Revocability:
I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

If desired, copy provided:
◯ *"Yes, I would like a copy of this form."*
(initialed by team member, copy provided by _____)

Practice Name: _____

Patient Name: _____

Date: _____

Signature: _____

If Personal Representative

Name: _____

Date: _____

Signature: _____

Relationship to Patient: _____

If Patient is a Minor

Parent / Legal Guardian: _____

Date: _____

Signature: _____

Form provided courtesy of:
MySocialPractice

This form is provided by My Social Practice for general convenience purposes and does not represent legal advice. Additional compliance rules vary from state to state, country to country. If you feel like you need legal consultation in addition to what we've provided, be sure to consult your practice attorney including seeking advice pertaining to HIPAA compliance, the HITECH Act, and the U.S. Department of Health and Human Services regulations. My Social Practice is a social media marketing company. We are NOT attorneys, and although this form is based on our own research to ensure compliance, it does not represent legal advice.

You may download this form as a PDF, at no charge, for printing yourself at: MySocialPractice.com/hipaaform

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