Authorization - Use or Disclose PHI - Testimonials, Photos, Social Media

Date: _____

Name: _____

Birth Date: _____ Last 4 Numbers Social Security # | | | | |

_____
Street Address Apt #

_____
City State ZIP

We appreciate the fact that you would like to provide information, a testimonial or comment about your experience or care you received from us. With your permission and authorization we may use your information in printed materials, on our web site, on social media we create and we may release it to the media. Please understand this may involve the use or disclosure of information protected by federal health privacy law that requires your authorization first. We will use or disclose only information you authorize. We may respond to a comment you post on social media we maintain or thank you for your testimonial. If we respond or thank you we will not use or disclose any information you have not previously authorized. This form explains your authorization. Please use it to authorize _____ to use or disclose your information. We will give you a copy.
(practice name)

Authorization (Enter practice name in the empty fields below, 1-4)

I authorize _____ , to use and disclose information described in Section 1 of this form to publish information, a testimonial or comment about my experience or care I have received. This includes posting my comment on social media maintained by or for _____ . My authorization to use my information extends to any persons working on behalf of _____ to create or maintain materials in any format that may include my information, testimonial or comment including but not limited to printed materials, web sites and social media. I authorize _____ to respond to any comment or testimonial I provide to the extent that its response does not use or disclose any protected health information other than the information described in this authorization.

1. Description of information to be used or disclosed
   For your convenience you may check one or more boxes describing information to be used or disclosed in your comment or testimonial.

   ☐ my photograph ☐ my name ☐ my initials only

   ☐ a comment I write ☐ recording (video or audio) of me

   ☐ my story – written by or for me

   ☐ any other information described in the box below

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2. Identification of persons to whom use or disclosure of the information described in Section 1 may be made
   The information described above may be used or disclosed to the general public who may view or read the information on materials created by or for _____ including but not limited to photographs, videos, printed materials, web sites and social media.
3. Purpose
   The purpose of this Authorization is to permit _____ to use or disclose the information described in Section 1 for public relations and marketing purposes by publication in any medium it creates or is created on its behalf including but not limited to its web site, social media, social media web site, newsletters, printed materials and press releases.
   _____ will not receive any payment or financial remuneration from anyone for use or disclosure of this information.
4. Expiration Date of this Authorization
   This authorization shall be valid - unless I revoke it earlier in writing - for ten (10) years following the date of the authorization.

I understand **(Enter practice name in the empty fields below, 1-6)**

1. I may revoke this authorization at any time by giving _____ notice of my revocation in writing. _____ will furnish me with a form to make my revocation but I do not have to use that form to make my written revocation.
2. My revocation of this authorization will not apply to information used or disclosed as permitted by this authorization before I give _____ written notice of my revocation.
3. _____ may not condition my treatment or payment, enrollment or eligibility for benefits on whether I sign this authorization.
4. Information disclosed as permitted by this authorization may be re-disclosed by persons who receive it and is no longer protected by federal health information privacy law.
5. I have a right to request and receive a copy of this authorization.
6. I will not receive any payment or financial remuneration for the information I am authorizing _____ to use and disclose by this authorization.

I understand this Authorization to Use or Disclose Protected Health Information for Testimonials and Social Media, signed it voluntarily and received a copy.

Signature, Individual/ Personal Representative _____

Name, Personal Representative (if any) _____

Personal Representative's Authority to Act _____

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☐ Identity of the Individual verified

or

☐ Identity, Authority to Act of Personal Representative verified

Received and confirmed for _____
(practice name)
by:

_____

Signature Printed Name and Title