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

Authorization:
I authorize the use and disclosure of my photo-graphic/ 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.

No Treatment Conditions:
I understand that the practice cannot condition treatment on whether or not I sign this authorization.

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

Practice Name: Affiliated Troy Dermatologists

Patient Name: ______________________________

Date: ______________________________

Signature: ______________________________

If Personal Representative

Name: ______________________________

Date: ______________________________

Signature: ______________________________

Relationship to Patient: ______________________________

If Patient is a Minor

Parent / Legal Guardian: ______________________________

Date: ______________________________

Signature: ______________________________