

**PATIENT AUTHORIZATION TO USE AND DISCLOSURE OF  
IMAGES, VIDEO, AND TESTIMONIALS ON SOCIAL MEDIA**

**1. Patient Information**

<b>Patient Name:</b>	
<b>Date of Birth:</b>	
<b>Practice Name:</b>	(the "Practice")
<b>Date:</b>	

**2. Authorization for Use and Disclosure of Images, Video, and Testimonial**

I authorize the Practice to use and disclose photographs, video recordings, audio recordings, written testimonials, or other media that may include my image, voice, name, or statements (collectively, "Media"), which may contain my Protected Health Information, for marketing, educational, and promotional purposes. Such use and disclosure may include publication on the Practice's website(s), social media account(s), digital communications, print materials, or other media.

The Media authorized for use and disclosure includes (check all that apply):

- photographs
- video recordings
- audio recordings
- written testimonials
- other (describe): \_\_\_\_\_

I understand that the Media may identify me directly or indirectly and may reveal information about my healthcare services.

**3. Voluntary Participation.** I understand that: (i) this authorization is completely voluntary; and I may refuse to sign this authorization without any impact the services that I receive from Practice.

**4. Social Media Disclosure.** I understand that: (i) Social media platforms are not controlled by Practice; (ii) once Media is posted, it may be shared, reposted, or reviewed by others beyond the Practice's control; and (iii) applicable privacy laws (including HIPAA) may not apply to third parties who receive the Media.

**5. Right to Revoke.** I understand that I have the right to revoke this authorization at any time in writing, except to the extent the Practice has already relied on it. Revocation will not require removal of Media already used or disclosed prior to the revocation. Revocation requests should be sent to the Practice.

**6. Acknowledgment.** By signing below, I confirm that I have read and understand this authorization and voluntarily agree to its terms.

<b>By:</b>	(signature)
<b>Patient Name:</b>	
<b>Date:</b>	