



## PATIENT MEDIA RELEASE & HIPAA AUTHORIZATION FORM

**Practice:** Asthma Allergy Care & Treatment

**Purpose:** This form authorizes the use of patient photos, videos, testimonials, and related media for marketing, education, website, social media, printed materials, and patient awareness.

### Authorization

I authorize Asthma Allergy Care & Treatment, its providers, staff, representatives, and affiliates to photograph, record, film, or otherwise capture my image, voice, likeness, testimonial, treatment area, and related media.

I understand these materials may be used for website content, social media posts, printed marketing materials, educational content, patient awareness campaigns, and before-and-after or treatment-related examples, if applicable.

I understand my image or information may be visible to the public once published. The practice will make reasonable efforts to protect my privacy; however, once media is posted online, it may be shared, copied, or redistributed by others.

### Information Authorized for Use or Disclosure

This authorization may include my photograph or video, voice or written testimonial, general treatment information, condition or service discussed, and before-and-after images, if applicable.

### Patient Rights

I understand I am not required to sign this form to receive medical care, treatment, payment, or benefits. Refusing to sign will not affect my care. I may revoke this authorization in writing at any time. Revocation will not affect any use or disclosure already made before the practice receives my written revocation. This authorization remains valid unless revoked in writing.

### Release

I release Asthma Allergy Care & Treatment, its providers, staff, representatives, and affiliates from any claims related to the authorized use of the media described above.

### Consent Selection

- I authorize use of my photo/video/media for marketing and educational purposes.
- I authorize use only if my name is not included.
- I authorize use only for internal educational purposes.
- I do not authorize use of my photo/video/media.

Patient Name

Date of Birth

Phone Number

Email Address

Patient Signature

Date

Parent/Guardian Name, if minor

Relationship to Patient

Parent/Guardian Signature

Date