HIPAA Patient Media Consent

Authorization:
I authorize the use and disclosure of my name, photo, 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's system listed. Revocation affects the disclosure moving forward and is not retroactive. This authorization expires 50 years from the date signed.

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

Practice Name: Columbia Eye/Columbia Eye Surgery Center

Patient Name: _____

Date: _____

Signature: _____

If Personal Representative
Name: _____

Signature: _____

Relationship to Patient: _____

If Patient is a Minor
Parent / Legal Guardian: _____

Date: _____

Signature: _____