HIPAA Release of Information MEDIA

RELEASE AUTHORIZATION FORM

I,_____,
hereby authorize JACKSON STREET PEDIATRICS, its duly authorized employees or agents, to publish the following personal health information/story/photograph/other identifying information:

_____

_____

_____

that may be used in print media, on our website, blog and/or on the social media platforms such as Facebook, Twitter, Pinterest, and You Tube.

The following information about me will not be disclosed:

_____.

I understand that any personal health information or other information released via the social media platform(s) above may be subject to re-disclosure by such social media platform(s) and may no longer be protected by applicable Federal and State privacy laws.

This authorization is valid from the date of my/my representative's signature below and shall expire on_____.

I understand that I have a right to revoke this authorization by providing written notice to this practice. However, this authorization may not be revoked if (Practice Name), its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Name of Patient: _____

Signature of Patient/Guardian: _____

Date: _____