Authorization For Use of Patient Photos/Videos on Social Media

PATIENT NAME DATE OF BIRTH

last	first	m	d	y
last	first	m	d	y
last	first	m	d	y

I, _____ ___ I do authorize ___I do **NOT** authorize

FULL NAME OF PARENT OR GUARDIAN

_____

SIGTNATURE RELATIONSHIP TO MINOR DATE

Authorization:

I authorize the use/share and disclosure of my name and/or my child(ren)'s name, photos/ video images for the use on **BEANSPROUT PEDIATRICS'** Social Media pages. 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 photos/videos 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.