HIBISCUS WOMEN'S CENTER II LLC
330 East Hibiscus Blvd
Melbourne, FL 32901
321-724-2229
Fax 321-728-6681

Photo, Video, Interview & Testimonial
Patient Authorization for Use & Disclosure of Protected Health Information for Practice Marketing

Authorization:

By my signature below, I affirm as a patient of Hibiscus Women's Center II LLC (the "Practice"), and/or as the parent or legal guardian of a minor child that is a patient of the Practice, that I authorize the Practice including its representatives and employees to post photographs, videos, and testimonials provided by me or taken by a Practice representative or employee on Practice related social media and websites, print publications, television, and on bulletin boards at the Practice.

I understand that the explicit purpose of this authorization is to permit the information to include images to be used for Practice advertising and marketing.

_____: I consent to the use of the above noted information for Practice advertising & marketing activities.

_____: I do not consent to the use of my information for Practice advertising & marketing activities.

Expiration and Revocability:

If Patient is signing on her own behalf, this authorization expires when the Patient informs the Practice that she is not longer a patient of the Practice or when the Practice terminates the Provider Patient Relationship. If Patient is signing on behalf of a minor child, this authorization expires when the Child reaches the age of majority, but the authorization remains valid for protected health information already used or disclosed until revoked by the Child who has attained majority. I understand that protected health information already used or disclosed prior to any revocation may no longer be protected.

I understand that I may revoke this authorization at any time by notifying the Practice in writing but that revocation will only affect uses and disclosures initiated after the date such written notice is received by the Practice. Upon receipt of the notice of revocation, the Practice will remove photographs from bulletin boards at the Practice's office. The Practice will make reasonable efforts to remove protected health information from websites and social media platforms over which it has control, but cannot guarantee removal from all sites. I understand that the Internet allows for wide sharing and forwarding of information and that the Practice cannot control all re-disclosure of information.

No Affect on Treatment:

This authorization is voluntary. I understand that the Practice cannot condition treatment of the Patient on whether I sign this Authorization, and that my decision not to sign will not influence or affect the Patient's treatment in any way.

Patient Name: _____

Signature of Patient and/or Parent/Legal Guardian: _____

Date of Signature: _____