CHRISTIE CLINIC
We listen. We care.

HIPAA AUTHORIZATION TO USE/DISCLOSE IMAGES AND HEALTH INFORMATION FOR MARKETING, PUBLIC RELATIONS AND EXTERNAL COMMUNICATIONS

I, the undersigned, hereby consent and authorize Christie Clinic, LLC, its affiliates, agents and healthcare providers ("Christie") to take photographs, slides, videotape, and any other means of recording or reproducing images of me ("Images") before, during and/or after my medical care and treatment. I authorize Christie to use and disclose the Images and use and disclose my health information in internal and external communications, productions and/or publications produced by or on behalf of Christie, including online, print, multimedia and news media. I also give my permission for Christie to release and disclose my Images and health information to news and electronic media including, but not limited to, internet/online publications, TV, radio, newspapers and/or magazines, and allow the news media to make images (digital, video, or otherwise) of me for purposes of illustrating my treatment and experience as a patient of Christie.

I understand that my name, picture or other details that would disclose my identity may be revealed. I hereby waive all my rights to inspect and approve the Images and finished materials. I relinquish all right, title and interest I may have in the Images and finished product. I waive any right to compensation for such uses, and me and my successors or assigns also release and hold harmless Christie from and against any claim for any injury in connection with the use, copying distribution or display of my image, voice, likeness, name or any other identifying characteristics in the broadcast or publication and any compensation resulting from the activities authorized by me in this authorization.

I understand the following:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected.
3. I may revoke this authorization at any time in writing, but if I do, it will not have an effect on any actions taken prior to receiving the revocation.
4. If the receiver is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I may have a copy of this form after I sign it.

This authorization will expire one year after the date below, or sooner by my choice (in which case this consent will expire on _____).

I have read and understand the terms of this authorization and I have had an opportunity to ask questions about Christie's use of my health information for possible use purposes of marketing and in broadcast or publication. I hereby knowingly and voluntarily consent to Christie using my health information for the purposes stated herein.

_____ _____

Signature of Individual/Patient Date