HIPAA RELEASE OF INFORMATION

MEDIA RELEASE AUTHORIZATION FORM

Austin Health Partners would like your permission to use quotes, images, and/or videos taken of you and/or your child to showcase on our websites, social media, print media and/or in office display.

Over 18 Years

I, _____, hereby consent to the taking of photographs and/or videos of me on behalf of Austin Health Partners. I also grant the right too edit, use and reuse said images and/or videos to promote Austin Health Partners, including in print, online, social media and all other forms of media. I consent to the use of my name and association with Austin Health Partners for the foregoing purposes. I give this authorization without expectations of compensation.

Pediatric Consent form Minors

I, _____, am the parent/guardian of _____, and I hereby consent to the taking of photographs and/or videos of him/her on behalf of Austin Health Partners. I also grant the right to edit, use and reuse said images and/or videos, including in print, online, social media and all other forms of media. I consent to the use of my child's name and association with Austin Health Partners for the foregoing purposes. I give this authorization without expectations of compensation.

This consent will remain in effect until I revoke it in writing. In signing below, I, on behalf of myself or the minor named herein, relinquish any rights or interest in the Information and release and discharge Austin Health Partners and any and all parties acting under Austin Health Partner's authority from any liability, claims, damages or causes of action that I may have in relation to their use, publication or other dissemination of any images or videos. I understand that I have the right to revoke this authorization in writing at any time; however, any such revocation shall be effective only as to the use of the Information subsequent thereto and shall not affect action that has been taken in reliance on this authorization.

I understand that any personal health information or other information released pursuant to this authorization may be subject to redisclosure by such social media platform(s) and other third parties and may no longer be protected by applicable Federal and State privacy laws.

By signing this form, I certify that I have read the above authorization and release and fully understand its terms.

Name of Patient: _____

Signature of Patient or parent/guardian of Patient: _____

Date: _____