HIPAA Release of Information

MEDIA RELEASE AUTHORIZATION FORM

(Sign and return with your testimonial about your experience at OSC)

I, _____, hereby authorize Orthopaedic & Spine Center, its duly authorized employees or agents, to publish the following personal health information/story:_____ (e.g., **my patient testimonial** or information relating to the diagnosis, treatment, and health care services provided to me and which identifies my name and other personally identifiable information) to be used in print media, on the radio, TV, the OSC website, blog and on the following social media platforms: Facebook, Twitter, Pinterest, and You Tube.

The following information about me will not be disclosed:
_____ *(Info not-to-be-disclosed includes your contact info and anything unrelated to your patient testimonial shared with OSC).*

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 _____ *(if left blank, until I retract it).*

I understand that I have a right to revoke this authorization by providing written notice to Orthopaedic & Spine Center. However, this authorization may not be revoked if Orthopaedic & Spine Center, 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.

Print Name: _____ Date: _____

Signature of Patient: _____

Email Address: _____

Phone Number: _____

OSC | ORTHOPAEDIC & SPINE CENTER

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