ELITE
Integrated Therapy Centers

This authorization form permits Elite Integrated Therapy Centers to use or disclose protected health information listed in the description section below for the following patient:

Name _____ Birth Date _____

Address _____

City _____ State _____ Zip _____

Entity or person to receive the information:

- General Public through Print Media, Facebook, Instagram, Linked In, YouTube, or Website

Description of information to be used or disclosed:

- Pictures, videos, testimonials, treatment documents, and/or recordings

Purpose of use or disclosure:

- Patient authorization for entity to disclose above information for advertising and/or educational purposes

Expiration date or event:

- Until revoked by patient

Rights of the Patient:

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that in the event I elect to revoke this authorization, current uses of this authorization already in effect may not change.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Signature of Patient or Personal Representative (as defined by HIPAA)

_____ Date _____

Description of Personal Representative's Authority (attach necessary documentation)

_____

FOR OFFICE USE ONLY: ☐ Copy given to patient

Receiving Employee: _____ Date Received: _____