HIPAA Release for Social Media Use

Our surgeons want our patients to be well-informed about their condition and surgeries. Part of this education comes from other patients. If you are interested in sharing your experience with other patients, either in an online forum, on social media, or through videos, please sign the release below.

HIPAA AUTHORIZATION AND RELEASE

I understand that my physician may, from time to time, desire to disclose certain information relating to me, my medical history, and/or the treatment(s) my physician provides to me, including some of my protected health information and/or identifiable health information. I further acknowledge and understand that such disclosure by my physician will be done in the medium of an advertisement for my physician's services and/or practice. **I hereby authorize and consent to my physician using and disclosing such information for such purposes** – and only for such purposes, which may include radio, television, print, and/or social media advertising. I further acknowledge and agree that such disclosure will only take place if and when I have agreed to speak about my experiences in dealing with my physician and that such discussion will necessarily disclose some of my protected health information.

This authorization and all of the provisions contained in it are effective immediately. This Authorization authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. 1320d, as amended (or any successor thereto), and the regulations applicable thereto, specifically 45 C.F.R. 160-164 (the "HIPAA Regulations"). Any word, any term and/or any phrase used in this Authorization that is defined in HIPAA and/or the HIPAA Regulations shall have the same meaning in this Authorization as ascribed to such word, term and/or phrase in HIPAA or the HIPAA Regulations, unless indicated to the contrary in this Authorization.

RELEASE

Each Covered Entity that acts in reliance on this Authorization shall be released from liability which would otherwise result from disclosing my individually identifiable health information and other medical records.

COPIES AND FACSIMILES

Copies or facsimiles of this Authorization shall be as valid as the original Authorization.

Signature: ____ Date: __________________

Name: ____

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