Authorization for Use or Disclosure of Protected Health Information for Marketing Purposes

Patient Authorization for Release of Information
I, the undersigned, hereby authorize **[Lotus Heals]** to use and/or disclose my Protected Health Information (PHI) as described below:

	Details
Information to be Used/Disclosed	*[Pictures or Videos of treatment process or results without identified name, contact information (email, phone number, address), age.*
Person(s) or Class of Persons Authorized to Make the Use/ Disclosure	*[Lotus Heals,Lotus Blossom Acupuncture PC]*.
Person(s) or Class of Persons to Whom the Information Will Be Disclosed	*[Social media platforms like Facebook and Tiktok]*.
Purpose of the Use or Disclosure	The purpose is for marketing communications related to acupuncture services. The clients are being encouraged to use the acupuncture services or health products we offered.

Financial Remuneration	**[Check one box]** □ **No,** [Name of Covered Entity] will not receive direct or indirect payment from a third party for this disclosure. □ **Yes,** [Name of Covered Entity] will receive financial remuneration from [Name of Third Party, if applicable] in exchange for making this disclosure.
Expiration Date or Event	This authorization is valid until **[Date]** OR upon the **[Event, e.g., "completion of the marketing campaign"]**. If left blank, it expires one year from the date signed.

Patient Rights

- Signing this authorization is voluntary and will not affect treatment, payment, health plan enrollment, or eligibility for benefits.
- This authorization can be revoked in writing at any time by contacting **[Privacy Officer/Michelle Anderson]** at **[Lotus Heals]**. The revocation is effective immediately, except for uses or disclosures already made based on the authorization.
- Information disclosed may be re-disclosed by the recipient and may no longer be protected by HIPAA privacy laws.

Acknowledgment and Signature

By signing, I confirm I have read, understand, and had my questions answered regarding this authorization.

Signature of Patient or Personal Representative:
Printed Name of Patient:
Date:

If signed by Personal Representative:
Relationship to Patient: _____