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Patient Testimonial Release and HIPAA Authorization

I hereby authorize Sutphin Chiropractic Acupuncture, PLLC and staff ("SCA") to document, record, photograph, videotape or otherwise memorialize me, my likeness, or image, and/or my testimonials and opinions, as indicated by my selections below (collectively referred to as the "Materials") and publicize those Materials, including via print materials and on social media, based on my preferences documented in this consent. I grant and release to SCA any and all rights, title, and interest that I might have in said the Materials, including photographs, videos, reproductions, and negatives.

Specifically, I consent to the publication or reproduction of the following (select all that apply):

- ☐ My written or published testimonials
- ☐ Photos or videos depicting me, my image or likeness related to my testimonials

I understand that by signing this authorization, SCA is permitted to use the Materials for its public relations and marketing activities, including the following forms:

- Social media, such as Facebook, Instagram,YouTube, Twitter, and similar outlets
- Websites and blogs, including SCA websites
- Print publications such as brochures or pamphlets
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I understand that the Materials may include my likeness and that certain information I provide in the Materials may include protected health information, such as information about the service I received from SCA. SCA is authorized to use and disclose my protected health information that may be contained in the Materials for social media or website content as described above to promote SCA services and to provide education regarding SCA services to potential patients.

I understand that I can decline to sign this authorization and it is not a condition to receive treatment from SCA. I also understand that I may revoke this authorization at any time with written notice to SCA, but that once any Materials have been published in reliance on this authorization, SCA cannot retrieve copies or prevent re-disclosure by others. I understand that once my information is released to third parties, it may no longer be protected by federal privacy laws and could be re-released. This authorization expires three years from the date of signature unless otherwise revoked.

I waive the right of prior approval and hereby release SCA from any and all claims for damage of any kind based on use of my Materials in accordance with this authorization. By signing below, I agree and acknowledge that I have read and understood the above Release and Authorization and agree to all terms described. I further acknowledge that I am of legal age and freely sign this form.

_____ _____

Patient Signature Patient Name

Date:_____