HIPAA Release of Information

MEDIA RELEASE AUTHORIZATION FORM

I, _____,

Authorize (Kids First Pediatrics), its duly authorized employees or agents, to publish the following personal health information/story/photograph/other identifying information that may be used in print media, on our website, blog and/or on the social media platforms such as Facebook or Instagram. (Please check one)

_____ I agree

_____ I do **not** agree.

The following information about me will **not** be disclosed:

_____

This authorization is valid from the date of my/my representative's signature below.

I understand that I have a right to revoke this authorization by providing written notice to this practice. However, this authorization may not be revoked if (Kds First Pediatrics), 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.

Name of Patient: _____

Signature of Patient/Guardian: _____

Date: _____