webpartners

Patient Authorization for Release of Health Information and Model Consent

Patient Name: _____

Practice Name: _____

Date: _____

I hereby authorize Web Partners, LLC (the "Producer") and the above-named Practice, its physicians or providers, subsidiaries, and any related organizations (the "Party" or "Parties") to use and disclose information about me for the purposes of creating press releases, news stories, photographs or video clips, website and/or publications, as well as pictures/graphics/video in which I may appear and/or be heard, for use in internal Party publications and/or disclosure to external (non-Party) media (collectively, the "Materials"). I agree to be photographed, videotaped, and/or recorded by the Parties for the purposes described herein.

The information about me may include my: name, treatment modality, age, duration of treatment, treatment plan, diagnoses, city and state of residence, photographs, video, voice, location of treating facility and information about my life and how I came to the Provider, and/or my on-going treatment. The information may also be disclosed to external media in the form of press releases, stories, photographs or video clips. It may also be used for internal purposes or on the Provider website or through Provider's own marketing or educational campaigns. Parties will not receive any direct or indirect payment from or on behalf of any third party in exchange for the release of this information about me.

I understand the provision of health care treatment, payment for my health care and my health care benefits are not dependent on this authorization. I understand I am not required to sign this authorization, however the information will not be used or disclosed without authorization.

I understand any information used or disclosed pursuant to this authorization may be subject to re-disclosure. I understand I have the right to revoke this authorization in writing, except to the extent information has already been released pursuant to this authorization at the time of the revocation. I can revoke this authorization by sending correspondence to the Administrator of the Provider listed above.

I understand that all the Materials, and all films, audiotapes, videotapes, reproductions, media, plates, negatives, photocopies, and electronic and digital copies of the Materials, are the sole property of the Parties. I agree not to contest the rights or authority granted to the Parties hereunder. I hereby forever release and discharge the Parties, its employees, licensees, agents, successors, and assigns from any claims, actions, damages, liabilities, costs, or demands whatsoever arising by reason of defamation, invasion of privacy, right of publicity, copyright infringement, or any other personal or property rights from or related to any use of the Materials or the release of information authorized above. I understand that the Parties is under no obligation to use the Materials.

This authorization will remain in effect for ten (10) years or the day my treatment relationship with Provider ceases or I revoke my permission.

_____ Date: _____

Signature of Patient or Personal Representative

If the patient is a minor or has a personal representative, I represent that I am the legal parent/guardian/personal representative of the Patient named above and I am not prohibited by Court Order from releasing access to the requested information.