Authorization to Release Protected Health Information
For Media Relations and Marketing Communications

Patient Name: _____ Phone Number: _____
Address: _____ Date of Birth: _____
_____ MRN: _____
_____

I, _____, hereby authorize Shoals Plastic Surgery/George R. Jennings, MD to use and/or disclose Protected Health Information about me or the above named patient for the purpose of providing information about the care received and my experience in marketing material, to the media or on social media.

1. The information may be used and/or disclosed to the following persons or organizations:
   a. Social media
   b. Print media
   c. General public
   d. Internal and external marketing brochures, flyers and other materials
   e. Shoals Plastic Surgery Website
   f. Other (please specify): _____
   _____

2. Information to be disclosed. The protected health information to be disclosed is limited to the following:
   ☐ Name
   ☐ Address
   ☐ Telephone number
   ☐ Description of health information about clinical care and medical needs related to the services and goods provided by the Facility
   ☑ Photographic Images
   ☐ Other (please specify):
   _____
   _____

3. Revocation. I understand that I may revoke this authorization at any time by sending a written notice to the Facility.

   SHOALS PLASTIC SURGERY
   GEORGE R. JENNINGS, MD
   203 W AVALON AVENUE
   MUSCLE SHOALS AL 35661

   However, the revocation will not have any effect on any uses or disclosures the Facility may have made before the revocation was received.

4. Expiration. I understand that unless I revoke the authorization earlier, this authorization will automatically expire when my relationship with the Facility terminates.

5. Re-Disclosure. I understand that information disclosed in accordance with this authorization may be disclosed to parties who are not obligated to protect it in the same manner as Facility and and could be redisclosed by the receiving party.

6. Refusal to Sign. I understand that I may refuse to sign this Authorization and that the Facility will not condition my receipt of care on whether I sign this Authorization.

7. Certification. I certify that I am the patient, and the identification that I have provided is true and correct or I am the patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct.

Signed this _____ day of _____, 20__.

Patient Signature: _____ Personal Representative Signature: _____

Print Name: _____ Print Name: _____

Relationship to the Patient: _____

(ONE COPY TO BE RETAINED BY THE PATIENT)

For Facility Use Only:

Date received: _____ Expiration date: _____
How was identity verified? _____ Copy made? ☐ Yes ☐ No
How was authority verified? _____ Copy made? ☐ Yes ☐ No

By: _____ Title: _____ Date: _____