

**AUTHORIZATION FOR RELEASE OF INFORMATION
FOR MEDIA/PUBLIC RELATIONS, FUNDRAISING AND MARKETING PURPOSES**

I authorize Women's Health Specialists ("WHS") to take and/or photographs, make audio and/or video recordings, interview me, and/or publish article(s) and information about me, my condition, or my treatment, including my protected health information and including the fact that I am a WHS patient, for the purpose of publicity, marketing, promotion and education in public communications, including, without limitation, publication in print, broadcast and electronic media. This authorization includes my name, my voice, my likeness on photo, visual recordings and digital media. This authorization applies to any photos, written, digital submissions and/or testimonial approved by me for:

- ☐ Print
- ☐ Social Media
- ☐ Website
- ☐ All marketing media
- ☐ Other _____

1. I understand that all such images, videos, interviews, recordings and information may be reprinted or rebroadcast by WHS and/or media outlets. I further understand that any persons and/or organizations that receive this information outside of WHS may not be subject to federal health privacy laws. I understand that information they receive may lose its protection under state and federal health privacy laws, and they may be permitted to re-release my medical information without my prior consent.
2. I understand that I am not required to sign this authorization and that my decision as to whether to sign this authorization will in no way influence the care or course of treatment, I receive from WHS or my eligibility for benefits.
3. I understand that I will receive no payment for the use of my name, voice, image, likeness, or information as described in this authorization and that I am granting a full license to WHS for use of the same.
4. I understand that I can revoke this authorization at any time by writing to: Privacy Officer, Women's Health Specialists 1818 N. Meade St. #330, Appleton, WI 54911. I understand that my revocation will be effective upon WHS's receipt of my revocation, except to the extent that WHS and/or its staff, representatives, licensees, and/or assigns have already taken action in reliance on this authorization (i.e., the revocation cannot be retroactive).
5. I understand that I have the right to inspect or copy the information I am authorizing the use or disclosure of, except for certain exceptions under state and federal law. I understand that if I would like to inspect the information that will be disclosed, I should contact the Privacy Officer at the address listed above.
6. Unless otherwise revoked, this authorization will be effective for the duration of uses listed on this form or until 1 year from the signature date below, whichever is sooner.

Name of Subject (Print)

Date of Birth

Name of Parent/Legal Guardian, if applicable (print)

I am the subject's ☐parent ☐legal guardian (check one)

Signature of Subject or Parent/Legal Guardian

Date

Witness Signature

Address (Street Address, City, State, Zip)

Phone Number

Email Address

PERSONS SIGNING THIS FORM ARE ENTITLED TO A COPY

Women's
Health Specialists®
YOUR FOX VALLEY OB/GYN PHYSICIANS