ALLIANCE
SPORTS MEDICINE

AUTHORIZATION FOR RELEASE OF INFORMATION
For Media, Public Relations, and Marketing Purposes

I, _____, authorize the above companies to take photographs, films, audio, video, or interviews of me for the purpose of marketing, research/education, or documentation.

1. I consent to the taking of photographs, films, audio, video, and interviews for use on our website and social media networks.

2. I understand that I may be identified in any use of the above materials.

3. I understand that Protected Health information including my name, diagnosis, and treatment/services may be identified in the above materials

4. I understand that I will not be compensated in any way for the taking and using of photographs, films, audio, video and interviews, or the publishing of said content.

5. I understand that at the time my health information is used or disclosed, it is no longer protected under state or federal law.

6. I understand that this authorization covers all periods of past, present, and future healthcare treatment to our facility.

7. I understand that I can cancel this Authorization at any time by mailing or personally delivering a written letter to **Alliance Sports Medicine,** 6110 McFarland Station Dr #400 Alpharetta, GA 30004

8. I understand that the terms of my treatment or payment will not be conditional upon signing this authorization.

9. I understand and acknowledge that my child/children are under 18 years of age, and lack the legal capacity to enter into binding agreements. As such, I have read this release, and consent to my child's/children's inclusion in the materials listed above.

10. I agree that I have received a signed copy of this Authorization.

_____ _____ _____
Signature of Patient, Parent, or Guardian | If Minor, name of child | Date

_____ _____
Signature of Witness | Date