PATIENT AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize Nashville Fertility Center to use/release protected health information (PHI) about me and/or my family.

Patient Name:
Partner Name:
Child's/Children's Name(s):

The information in this authorization is to be used or disclosed for the following purposes:

- Posted on social media – Facebook, Twitter, Instagram, Youtube and Google
- Used on the NFC website – www.NashvilleFertility.com
- Sent to the media (TV, Radio, newspaper, magazine)

Specifically, this authorization permits Nashville Fertility Center to use the following PHI about me: photos, videos, audio of my voice, my fertility story that includes protect health information about my medical conditions, diagnosis and treatments with/and prior to being seen at Nashville Fertility Center.

I understand that my information may not be protected from re-disclosure once it has been released pursuant to this authorization.

I understand that my treatment may not be conditioned on signing this authorization.

I understand I have the right to revoke this authorization by written notification to the health care provider to which this authorization is submitted. The provider must comply except to the extent that the provider has already acted in reliance upon this authorization.

_____ _____
Patient's Signature Relationship to Patient

_____ _____
Patient's Printed Name Date

_____
Print Name of Patient or Legal Guardian