PATIENT AUTHORIZATION FOR USE & DISCLOSURE OF PHI FOR MARKETING PURPOSES & USE OF LIKENESS

MaxHealth

PURPOSE OF CONSENT

MaxHealth creates and maintains information about its patients in order to market its services to existing and prospective patients, as well as to provide general health information and educational purposes. This information, which is referred to as protected health information ("PHI"), is subject to certain privacy protections under the Health Insurance Portability and Accountability Act ("HIPAA") of 1996. By signing this authorization form, you are authorizing MaxHealth to use and disclose your PHI, as set forth below.

CONSENT TO RELEASE

1. I authorize MaxHealth to use and disclose the following PHI:

   My full name, age, city and state of residence, biographical information, telephone number, mailing address, and email address, to communicate with me about MaxHealth's products, services, community events, or other general health information.

   MaxHealth is also authorized to use and disclose to the general public my testimonial, verbal or written statements, quotes, likeness, photographs, name, pictorial images, social media publications, biographical information, and/or other likeness of myself in internal and external media, including, websites and social media accounts in conjunction with MaxHealth business efforts, marketing, advertising, promotional activities, publicity, materials, and/or programs.

2. I understand MaxHealth will not receive financial compensation for the use of my PHI. I also acknowledge that I will not receive any payment or other compensation from MaxHealth for the use of my PHI.

3. MaxHealth is authorized to disclose my PHI to the following persons and/or entities:

   General public through internal and external (non-MaxHealth) media, including but not limited to, television, radio, newspaper, Internet, publications, websites and social media accounts.

4. I authorize MaxHealth to use and disclose my PHI for the following purposes:

   Marketing, advertising, and promoting MaxHealth's services to the general public through internal and external (non-MaxHealth) media, including but not limited to, television, radio, newspaper, Internet, publications, websites and social media accounts, as well as through communication with existing and prospective patients.

5. I acknowledge that I have the right to refuse to sign this authorization and MaxHealth may not condition the provision of health care on signing this authorization. I may revoke this authorization by submitting my request in writing to MaxHealth. I understand that such revocation will not apply to actions already taken or communications already made by MaxHealth prior to my revocation. If

I do not revoke this authorization, this authorization will expire 50 years from the date signed below.

6. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA privacy regulations.

By signing this authorization, I acknowledge that I have read and understand the information above. I further acknowledge I have signed this consent voluntarily.

PATIENT

_____	_____	_____
Print Name	*Signature*	*Date*

_____

Mailing Address

_____	_____
Email Address	*Phone Number*

PERSONAL REPRESENTATIVE

_____	_____	_____
Print Name	*Signature*	*Date*

_____

Relationship to Patient

PATIENT IS MINOR

_____	_____	_____
Parent/Legal Guardian Name	*Signature*	*Date*