Nash Dermatology, LLC

Patient HIPAA Authorization for Use and/or Disclosure of Protected Health Information for Marketing Purposes

Patient Name:	Date of Birth:

By signing below, I hereby authorize Nash Dermatology, LLC and its physicians, employees, and/or contractors (collectively, "Nash Dermatology"), to use and disclose to the general public for marketing, advertising, promotions, education and/or training purposes through print, visual, electronic or any other form or medium, including, but not limited to, publication on the Nash Dermatology website and social media channels, the above-named patient's photographic images taken by Nash Dermatology along with the patient's health information related to such photographs. Notwithstanding, the patient's name will not be disclosed pursuant to this Authorization.

By providing this Authorization, I understand as follows:

1. I understand that such photographs and patient health information may be used and/or disclosed without further approval by or notification to me.

2. I understand that this Authorization is voluntary. I may refuse to sign this Authorization and the above-named patient's treatment and/or payment obligations will not be affected.

3. I understand that Nash Dermatology will not receive financial or in-kind compensation or remuneration in exchange for the use and/or disclosure of the above-named patient's photographs and health information unless an applicable legal exception applies.

4. I understand that any photographs shall become the property of Nash Dermatology. I understand that, by signing this Authorization, I release to Nash Dermatology any rights, title and/or interest of any kind that I may have in the photographs.

5. I understand that the photographs and patient health information may be placed on the Nash Dermatology website, social media channels, or elsewhere and will be seen by members of the general public.

6. I understand that the photographs and patient health information to be disclosed may be subject to redisclosure and may no longer be protected by federal or state law.

7. I understand that this Authorization is continuous in nature and is to be given full force and effect, including disclosing and/or utilizing any and all of the foregoing information learned or determined after the date hereof but prior to the expiration date of this Authorization.

8. I understand that I may revoke this Authorization at any time by written notice to Nash Dermatology, but if I do it will not have any effect on uses or disclosures occurring prior to the receipt of the revocation. Unless otherwise revoked, this Authorization will expire five (5) years after the date below.

9. I understand that, upon request, I may receive a copy of this Authorization form after I sign it.

10. I understand that a photocopy or facsimile of this Authorization shall be valid and effective, just as the original.

_____ _____

Signature of Patient or Patient's Representative Date

_____

Printed Name of Patient's Representative (*if applicable*)

_____

Representative's Relationship to Patient (*if applicable*)