MEDIA CONSENT FORM

This form provides consent for the use of photographs, video recordings, and/or other related media involving the individual named below. This consent complies with all relevant healthcare privacy laws, including HIPAA (Health Insurance Portability and Accountability Act).

Patient Information:
Medical Record Number: _____ Name: _____

Authorization for Use/Disclosure:
I, the undersigned, authorize Hurtt Family Health Clinic, its representatives, and affiliates, including healthcare providers, communications staff, and approved third parties, to obtain photographs, video or film in which I appear, herein referenced as media.

Purpose of Use/Disclosure:
The media will be used for the following purposes:

- Social media (e.g. Facebook, Instagram, LinkedIn)
- Newsletters
- Hurtt Family Health Clinic website
- Other platforms that Hurtt Family Health Clinic manages for public use

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Terms and Conditions:

- I understand that the media may be used or disclosed for the purposes stated above and may be shared with third parties (e.g., media outlets, public platforms).
- I understand that I may refuse to sign this form and that my refusal will not affect my medical treatment, payment, or eligibility for benefits.
- I may revoke this consent at any time by providing a written notice to Hurtt Family Health Clinic. However, such revocation will not apply to materials already in use or prepared prior to the revocation.
- I acknowledge that I am not entitled to compensation for the use of the media or related materials.

Expiration of Authorization:
This consent will remain in effect until:

- Date: _____ Leave blank if you choose not to expire this consent.

Acknowledgment and Release:

☐ I hereby release and hold harmless Hurtt Family Health Clinic, its representatives, and third parties authorized under this consent from any and all liability arising from the use or disclosure of the authorized media.

Patient's Signature: _____ Date: _____

If the patient is a minor or unable to consent:

Name of Representative: _____ Relationship to Patient: _____

Representative's Signature: _____ Date: _____

OR

☐ **Refuse to give consent** Sign: _____ Date: _____