Photo and Video Consent Form

I, _____, authorize Orlando Neuro Therapy and its employees, agents, and authorized representatives, to use and/or disclose my Protected Health Information contained in any photographs, videos, medical and physical therapy records, and/or audio recordings for the following purposes:

- ❑ Use in internal and external advertising, marketing, public relations or collateral materials, including but not limited to posting on Orlando Neuro Therapy's website and social media sites.
- ❑ Use in news releases or stories, including television, newspaper, or radio broadcasts.
- ❑ Use in internal and external education and/or training programs for the public and/or medical professionals, including but not limited to use on public websites and social media sites.

I further authorize Orlando Neuro Therapy to use and/or disclose the following information personal information in conjunction with the use/disclosure of my photographs, videos and/or audio recordings:

- ❑ My name
- ❑ My demographic information
- ❑ Information about my diagnosis, physical therapy problems, basic treatment information, or other personal information necessary to accomplish the purpose of the marketing/promotional effort, except as specifically described as follows (please describe if applicable):_____

I provide my authorization knowing that:

- The Protected Health Information that is used or disclosed pursuant to this authorization, including Protected Health Information contained in any photographs, videotapes, or interviews, may be subject to re-disclosure by the recipient(s) and may no longer be protected by HIPAA or other state or federal laws.
- Signing this authorization is voluntary. I have the right to refuse to sign this authorization.
- My treatment, payment, enrollment in a health plan, or eligibility for benefits is not conditioned on my provision of this authorization.
- I understand that I can revoke or cancel this authorization at any time by sending written notice to:

  Orlando Neuro Therapy
  Attn: Tara Tobias
  1300 N Semoran Blvd Suite 165
  Orlando Fl 32807
- If I revoke or cancel this authorization, I understand that the revocation will not apply to Protected Health Information that has already been used or disclosed in reliance on my authorization.
- I am entitled to receive a copy of this Authorization upon request.

Unless I revoke this authorization, it will expire 30 months from the date signed below.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

Legal Representative (Print name, if applicable): _____

Legal Representative Signature: _____ Date: _____

Legal Representatives Relationship to Patient (if applicable): _____