Marketing Release Authorization

I, _____, hereby authorize Phillips Pediatrics to distribute and share personal content for the purpose of company marketing and promotion.

I agree that I am voluntarily sharing information that may include protected health information (PHI) and am receiving NO financial advantage from Phillips Pediatrics. Per HIPAA regulation, no other PHI will be used without prior authorization.

Marketing and promotional content may include my name, location, and product/ service(s) rendered, photographs approved by me, and testimonials that I have provided to the company.

☐ I prefer content only to include my: _____.

Content may be distributed by Phillips Pediatrics in various platforms, including print, online, the company's website, and social media pages.

☐ I consent only to distribution in: _____.

Unless otherwise indicated, this authorization automatically expires 21 years from the date of signature. You may revoke this authorization in writing submitted at any time to the organization. Once this authorization expires or is revoked, the organization will not use your content for future marketing purposes. Any prior uses, disclosures, or circulating material will not be subject to the revocation of this authorization.

☐ This authorization is to expire (specify date): _____.

Signature: _____

Relationship to Patient(s): _____ **Date:** _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

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