Coos Health & Wellness
Together, Inspiring Healthier Communities

Promotes and provides innovative quality health services, prevention, and education for our communities

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CLIENT AUTHORIZATION TO USE OR DISCLOSE TESTIMONIALS, PHOTOS, SOCIAL MEDIA

Name: _____ Address: _____

By signing below, I voluntarily agree to provide a testimonial about my experience with Coos Health & Wellness ("CHW") in printed and electronic promotional materials on CHW's web site, social media, or in other media/news outlets. I consent and authorize for CHW to use and disclose my photograph, name, testimonials, and other information/comments about my experience with CHW or at an event sponsored by CHW (my "Information"). I understand that:

1. My testimonial may reveal or suggest that I am a client of CHW, and may contain protected health information that is protected under HIPAA.
2. I may revoke this authorization at any time by giving CHW notice of my revocation in writing, but I understand that my revocation will not apply to information used or disclosed by CHW prior to receipt of written notice of my revocation.
3. CHW may not condition my treatment or payment, enrollment, or eligibility for benefits on whether I sign this authorization.
4. Information disclosed as permitted by this authorization may be re-disclosed by persons who receive it.
5. I can request and receive a copy of this authorization.
6. I will not receive any payment or financial remuneration for the information I am authorizing CHW to use and disclose by this authorization.
7. I release and discharge CHW (including without limitation all officers, directors, employees, and agents) from any and all claims, liability, actions, suits, demands, costs, expenses arising out of, related to, or in any way connected with the use of images or disclosure of the information and materials described herein, and I hereby waive all rights and interest in and to such information and materials.
8. Unless otherwise revoked, this authorization will expire three (3) years after the date of my signature.

Signature _____ _____
Date

Guardian Signature _____ _____
(if applicable) Date

Guardian Relationship/Authority _____
(if applicable)

IMPORTANT: If you are a current or former patient of CHW, the testimonials and social media posts may contain protected health information (PHI) that may require your authorization prior to use for marketing purposes. If you agree to allow us to use your Information, this authorization supplements and amends any prior HIPAA acknowledgement or authorization you previously provided.