HIPAA Authorization for Marketing Purposes Form

This form authorizes the use or disclosure of protected health information (PHI) for marketing purposes, in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

1. Patient Information

Patient Full Name: _____

Date of Birth: MM/DD/YYYY

Street Address: _____

City, State, Zip: _____

Phone Number: _____

Email Address: _____

2. Authorization for Disclosure

I hereby authorize the following entity to make the disclosure of my protected health information:

Disclosing Entity (Name of Clinic, Practice, or Provider): _____

I authorize the information to be disclosed to and used by the following recipient(s) for marketing purposes:

Receiving Entity/Company Name: _____

Recipient Contact Person/Role: _____

3. Description of Health Information to Be Disclosed

Specify the health information authorized for use or disclosure (e.g., patient testimonials, photos, medical condition details, treatment history):

_____

4. Description of Marketing Activity

Describe the specific marketing campaign, material, or purpose for which the information will be used (e.g., social media post, website feature, email newsletter):

_____

5. Financial Remuneration

HIPAA requires the disclosure of whether the covered entity will receive direct or indirect financial remuneration (payment) from a third party as a result of this authorization.

Will the disclosing entity receive financial compensation for using or disclosing this information? (Type YES or NO): _____

6. Patient Rights and Acknowledgements

- I understand that I have the right to revoke this authorization at any time by submitting a written revocation to the disclosing entity, except to the extent that action has already been taken in reliance on this authorization.
- I understand that my treatment, payment, enrollment, or eligibility for benefits cannot be conditioned on whether I sign this authorization.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

7. Expiration

This authorization will expire on the following date or event (e.g., "End of marketing campaign", "1 Year from signature date"):

Expiration Date or Event: _____

8. Signature

By signing below, I acknowledge that I have read and understand this authorization form, and I voluntarily consent to the use and disclosure of my health information as described above.

Patient or Personal Representative Signature: Sign here upon printing

Date: MM/DD/YYYY

If signed by a Personal Representative, describe relationship to patient: _____