Northwest Anesthesiology and Pain Services, PA

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PHOTOGRAPHY, VIDEO/AUDIO RECORDINGS AND/OR TELEVISED SESSIONS OF PATIENTS

(Images to be used or disclosed for purposes other than treatment, payment and/or health care operations, such as, but limited to advertising or marketing)

Patient Name: _____

Last **First** **M.I.**

Date of Birth: _____

1. The following information can be used and/or disclosed: *(check all that apply and provide a description)*
   - ☐ Photographs _____
   - ☐ Video/Audio Recordings _____
   - ☐ Other: _____
2. I authorize Northwest Anesthesiology and Pain Service, PA (NWAP) to disclose the information (as described above) to:

Name:

_____

Address:

_____

City, State, Zip **Telephone Number:** _____

3. If this authorization is for any purpose other than the release of PHI for personal reasons, please state the purpose below:

_____

4. This authorization will expire on the 180th day of the signing or as otherwise specified below:

_____

5. I understand this authorization is voluntary and I may refuse to sign. NWAP may not withhold treatment based on the completion of this authorization.

6. The information to be used or disclosed pursuant to this authorization form may include information relating to: (1) Acquired immunodeficiency syndrome (AIDS) or (2) human immunodeficiency virus (HIV) infection, treatment for drug or alcohol abuse, or (3) mental or behavioral health or psychiatric care.

7. I understand that I may revoke this authorization at any time by notifying NWAP in writing to the following address: *7010 Champions Plaza Dr, Suite 400; Houston, TX 77069*, of my intent to revoke this authorization. I understand that such a revocation will not have any effect on any information already used or disclosed by NWAP before NWAP received my written notice of revocation.

8. If neither federal nor Texas privacy law apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Texas privacy laws.

_____ _____

Signature of the Patient or Personal Representative Date

Northwest Anesthesiology and Pain Service, PA
7010 Champion Plaza Dr, Suite 400
Houston, TX 77069
T (832) 698-5320
F (832) 698-5321