HIPAA Authorization for Use/Disclosure of Information and Consent/Use of Photographs and Audio/Video Images

16350 E Arapahoe Rd, Ste 146
Foxfield, CO 80016
720.949.4078 phone
720.420.1787 fax

Effective date September 15, 2021

Kid Physical LLC ("Kid Physical") is always pleased when patients are willing to communicate the stories, experiences, and information about their treatment received from our providers. Sharing your story can help others who are interested in knowing more about the patient services provided by Kid Physical and can help Kid Physical promote its mission of service.

Kid Physical respects the privacy of our patients, visitors, and staff. Ensuring that medical information is kept confidential is among our highest priorities. Kid Physical seeks your permission to use your medical information and your consent to allow us to take and use audio/video/photographic material of you in Kid Physical's internal and external communications, including medical and general interest publications and medical and patient education information, and distribute such materials online, in print, and in news media (such as TV, radio, newspapers, and magazines).

To ensure that Kid Physical is acting in accordance with your wishes, and using your personal information with your authorization, we ask you to fill out and sign this form. Kid Physical will keep a copy of your written permission on file.

- ☐ I do give my permission for Kid Physical to use my or my child's name and share details of my or his/her treatment and experience as a patient in communications produced by or on behalf of Kid Physical. This permission extends both to electronic versions on the Kid Physical websites and other internet electronic applications as well as to printed, filmed, and taped versions.

- ☐ I do give my permission and consent for Kid Physical to take and make use of my and/or my child's audio/video/photographic images in publications produced by or on behalf of Kid Physical. This permission extends both to electronic versions on the Kid Physical websites and other internet electronic applications as well as to printed, filmed, and taped versions.

- ☐ I specifically authorize the release of information pertaining to diagnosis and treatment, including alcohol, drug, and/or substance abuse.

- ☐ I specifically authorize the release of information pertaining diagnosis and treatment of mental health.

- ☐ I specifically authorize the release of information pertaining diagnosis and treatment of HIV/AIDS including test results.

I am not required to sign this authorization. Kid Physical does not condition treatment, payment, benefit eligibility, or enrollment activities on the signing of this form. I can request a copy of this authorization be mailed to me. I understand that I will not be entitled to any payment or other form of remuneration as a result of any use of any information and audio/video/photographic material.

If I decide to sign this form, I have the right to request that audio/video recording, filming, or photographing cease at any time.

I am aware that my protected health information will exist forever in either a rec orded, printed, and/or electronic version or other version as many develop over time and that once it is published or disclosed in any form it will continue to be used. I understand that information about me or my child used or disclosed pursuant to this authorization may be subject t to re-disclosure by the recipient and will no longer be protected by the federal regulations protecting privacy of an individual's health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable federal and state law.

I understand that I may revoke or withdraw this permission at any time to prohibit future use of my information. To do so, I must send written notice to Kid Physical at 16350 E Arapahoe Rd Suite 146, Foxfield, CO 80016. I understand that Kid Physical, as well as other persons or entities, will retain copies of any such electronic or printed versions and shall retain these versions forever and that any revocation of this authorization will only extend to the versions of the information within Kid Physical's control that have not been previously published. If not revoked/withdrawn by me, this authorization expires ten (10) years from the date that I sign it.

Patient Name: _____

Address: _____

Phone: _____

Parent/Guardian Signature: _____ Date: _____

For personal representatives, please provide the following:

I _____ represent that I am the healthcare agent/guardian/surrogate/parent of the patient above. __ (circle one of the above)

Personal Representative Signature:

Address: _____

Phone: _____

This notice is effective in its entirety as of September 15, 2021.