HIPAA Authorization for Use and Disclosure of PHI for

Marketing and/or Promotional Purposes

I, _____, authorize Kid O'Therapy, LLC, and its employees, agents, and authorized representatives, to use and/or disclose my Protected Health Information contained in any photographs, videos, medical and physical therapy records, and/or audio recordings for the following purposes: (Check all that apply)

- ❑ Use in internal and external advertising, marketing, public relations or collateral materials, including but not limited to posting on Kid O'Therapy's website and social media sites.
- ❑ Use in news releases or stories, including television, newspaper, or radio broadcasts.
- ❑ Use in internal and external education and/or training programs for the public and/or medical professionals, including but not limited to use on public websites and social media sites.

I further authorize Kid O'Therapy, LLC to use and/or disclose the following information personal information in conjunction with the use/disclosure of my photographs, videos and/or audio recordings:

- ❑ My name
- ❑ My demographic information
- ❑ Information about my diagnosis, physical therapy problems, basic treatment information, or other personal information necessary to accomplish the purpose of the marketing/promotional effort, except as specifically described as follows (please describe if applicable):_____
  _____

I provide my authorization knowing that:

- The Protected Health Information that is used or disclosed pursuant to this authorization, including Protected Health Information contained in any photographs, videotapes, or interviews, may be subject to re-disclosure by the recipient(s) and may no longer be protected by HIPAA or other state or federal laws.
- Signing this authorization is voluntary. I have the right to refuse to sign this authorization.
- My treatment, payment, enrollment in a health plan, or eligibility for benefits is not conditioned on my provision of this authorization.
- I understand that I can revoke or cancel this authorization at any time by sending written notice to:

Kid O'Therapy, LLC
Attn: Kimberly Chonko, Owner
41 Main Street
Topsham, Maine 040867

Mailing Address:
Kid O'Therapy, LLC
Attn: Kimberly Chonko, Owner
126 Main Street Suite #3
Topsham, Maine 04086

- If I revoke or cancel this authorization, I understand that the revocation will not apply to Protected Health Information that has already been used or disclosed in reliance on my authorization.
- I am entitled to receive a copy of this Authorization upon request.

Unless I revoke this authorization, it will expire 30 months from the date signed below.

Patient Name (Print): _____

Patient Signature: _____

Date: _____

Legal Representative (Print name, if applicable): _____

Legal Representative Signature: _____

Date: _____

Legal Representatives Relationship to Patient (if applicable): _____

Consent and Release for Use and Disclosure of Image, Voice, and/or Written Testimonials

---

I, _____ consent to the photographing, recording and unlimited use of my likeness (including my name, voice and/or image) for commercial, promotional or other use, in any medium, including use on the internet and social media, by Kid O'Therapy, LLC and its employees, affiliates, subsidiaries, licensees, successors, and assigns. I waive all rights of attribution, inspection, or approval for any use of my likeness. I understand that Kid O'Therapy, LLC has no control over how my photos, videos or testimonials may be used by others once they are published on the internet. Kid O'Therapy, LLC and its employees, affiliates, subsidiaries, licensees, successors, and assigns are held expressly harmless for any liability, legal and/or financial, incurred as a result of said use. I waive any right to royalties or other compensation arising from or related to the use of my likeness. All right, title, and interest to any photographs, recordings, and any other materials using my likeness shall be the sole property of Kid O'Therapy, LLC. I shall have no interest in any such materials, nor shall I have any right to use the name or trademarks of Kid O'Therapy, LLC without its express, written permission. If I decide I do not want Kid O'Therapy, LLC to use my photos, videos, testimonials or other likeness, I may revoke this Consent and Release for new future uses but Kid O'Therapy, LLC shall have no obligation to remove my photos, videos, testimonials or other likeness in its promotional, commercial, educational, or other materials that are already in use.

I HEREBY ACKNOWLEDGE THAT KID O'THERAPY, LLC OR ANY OF ITS AGENTS OR EMPLOYEES HAVE NOT MADE ANY REPRESENTATIONS OR WARRANTIES OF ANY KIND WITH RESPECT TO ANY MEDICAL OR OTHER ADVICE OR INFORMATION THAT I MAY RECEIVE IN CONNECTION WITH MY APPEARANCE AND THAT I HAVE NOT RELIED ON ANY SUCH REPRESENTATIONS OR WARRANTIES IN AGREEING TO PARTICIPATE IN THE RECORDING OF MY VOICE AND/OR LIKENESS AS DESCRIBED ABOVE OR IN THE EXECUTION OF THIS CONSENT FOR USE AND DISCLOSURE OF IMAGE, VOICE AND/OR WRITTEN TESTIMONIALS (THE "CONSENT").

I am signing this Consent and Release voluntarily, having read it in its entirety and understanding the contents thereof to my satisfaction, and I acknowledge that it is binding upon me, my legal representatives, heirs and assigns. I understand that this Consent will be signed contemporaneously with the form entitled Authorization for Use and Disclosure of Protected Health Information for Marketing and Promotional Purposes (the "Authorization"), and I agree that in the event of conflict between the two documents, the terms of the Authorization shall govern.

Printed Name: _____

Signature: _____

Date: _____