Effective Date: _____

Authorization to Use and Disclose Protected Health Information for Marketing Purposes

This form authorizes JENNIFER DAVIS, DPT, dba Oregon Running Clinic, to use and disclose your protected health information for marketing purposes. We may not condition your treatment on your acceptance. Please read this form carefully.

We will use or disclose the following information: [_____] [Note: if financial payment is received for communicating the information, make sure to disclose that in this form].

[Insert the name of the person(s)_____] [is/are] authorized to make use of or disclose the information above on behalf of the clinic. [Insert the name of the person(s)_____] will receive disclosures from the clinic.

The information will be used for the following purposes: [Insert a description of each purpose of the requested use or disclosure_____]. Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by HIPAA privacy rules.

This authorization will be valid until [Insert an expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure_____]. Additionally, you have the right to revoke this authorization at any time by submitting a written request to Jennifer Davis, DPT, except to the extent that our clinic has already made disclosures pursuant to this authorization.

I acknowledge I have read the foregoing information and understand the contents.

_____
Patient Signature

_____
Date

_____
Patient's Personal Representative (if applicable)

_____
Relationship

_____
Date