Patient Consent for Photographs and Interviews

I give my consent for Dynamic Strides Therapy, Inc. ("DST"), and/or its representatives or affiliates, to take and use photographs or films of me and/or interview me for publicity, educational, marketing, DST training, advertising and fundraising purposes through internal publication, external publication, radio, television, video or internet. *[I have crossed out any purposes or media formats I do not wish included.]* Such photographs, films and/or interview content will disclose the fact that I have been a patient of DST and may contain other information about me, including what I say in the interview, facts that can be inferred from the photograph or film, or personal health information that may be covered by the Health Insurance Portability and Accountability Act of 1996, its related regulations, and/or applicable state law.

- I understand that I am not required to sign this form in order to receive treatment or payment for my care.
- I understand that information used or disclosed under this authorization may be reused by the recipient and may no longer be protected by privacy regulations.
- I understand that I may revoke this authorization at any time by notifying DST in writing, and the revocation will be effective on the date notified (except to the extent action has already been taken based on my earlier consent).
- I understand that this authorization will expire in seventy-five (75) years, unless I have given written notification stating otherwise.
- I understand that neither I nor DST will receive direct or indirect payment for the communication related to this photo, film or interview.

My name….(check one):

- € May be used in connection with any photographs, videos, interviews, or other media formats I have approved above.
- € May not be used in connection with any photographs, videos, interviews, or other media formats I have approved above.

Patient Name: _____

Street Address: _____

City, State, Zip: _____

Phone Number: _____

Patient Signature: _____

Parent/Legal Guardian Name (if Patient is a minor): _____

Parent/Legal Guardian Relationship to Patient: _____

Parent/Legal Guardian Signature: _____

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