

Media Release and Authorization to Use and Disclose Health Information

Name: _____

Date of Birth: _____

Email: _____

Phone Number: _____

I, _____, hereby grant _____ (the "Treatment Center"), its representatives, employees, agents, and affiliates (collectively referred to as "the Center"), the unrestricted right and permission to use my image, likeness, video recordings, and/or voice recordings, together with any written or spoken statements I provide, including statements about my treatment and recovery (hereinafter referred to as "Media"), for promotional and marketing purposes. This grant is perpetual and irrevocable to the fullest extent permitted by law, subject to the health information revocation rights described below.

Purpose of Use

I understand that the Media may be used for any of the following purposes:

- **Website Content**
- **Social Media** (Facebook, Instagram, YouTube, LinkedIn, etc.)
- **Marketing & Advertising Materials** (brochures, flyers, digital ads, billboards, etc.)
- **Educational or Promotional Videos**
- **Public Relations Efforts**
- **Testimonials & Success Stories** featuring my recovery story in my own words

I acknowledge that the Center may edit, modify, reproduce, distribute, and display the Media in any format, now known or developed in the future, in perpetuity, without any obligation to notify or compensate me.

Authorization to Use and Disclose Protected Health Information

I understand that the fact of my participation in a program at the Center, my identity as a person who has received substance use disorder or mental health treatment, and any statements I make about my diagnosis, treatment, or recovery are protected health information under the Health Insurance Portability and Accountability Act (HIPAA) and, where applicable, federal confidentiality regulations at 42 CFR Part 2.

By signing this form, I voluntarily authorize the Center to use and disclose the following information about me for marketing and promotional purposes: my name, image, likeness, photographs, video recordings, voice recordings, the fact that I received treatment at the Center, and any details about my treatment, diagnosis, health history, or recovery that I choose to share in my statements, testimonials, or recorded Media.

This information may be disclosed to the general public through the channels listed under Purpose of Use above. The purpose of this use and disclosure is marketing, advertising, and promotion of the Center and its programs.

I understand that once my health information is disclosed publicly under this authorization, it may be redisclosed by others and may no longer be protected by HIPAA or 42 CFR Part 2. I understand that the Center will not receive payment from any third party in exchange for my health information. This authorization will remain in effect until I revoke it in writing.

Waiver of Rights

I waive any rights to inspect or approve the Media before it is used. I further release and discharge the Center from any and all claims, demands, or causes of action arising out of or related to the use of the Media, including but not limited to claims of invasion of privacy, defamation, or misrepresentation.

Confidentiality

I acknowledge that participation in any program at the Center is confidential. I consent to the use of my Media, and to the disclosure of my personal health information contained within it, solely to the extent described in this form. No personal health information or details of my treatment beyond what I choose to share in my Media will be disclosed without my explicit permission, unless required by law.

Voluntary Participation

I confirm that my participation is entirely voluntary, and I have not been promised any financial compensation, gifts, or special treatment in exchange for signing this release. I understand that the Center will not condition my treatment, payment, enrollment, or eligibility for services on whether I sign this authorization, and that I may refuse to sign without any effect on my care.

Revocation Rights

I understand that I have the right to revoke this consent and authorization at any time by submitting a written revocation to the Center. If revoked, the Center will make reasonable efforts to discontinue using my Media and health information in future materials, but my revocation will not apply to uses and disclosures already made in reliance on this authorization, and the Center cannot remove previously published or distributed content.

Acknowledgment & Signature

I have read and understand this release and authorization form. I am signing this agreement voluntarily and fully understand its contents. I acknowledge that I have been offered a copy of this signed form for my records.

Signature: _____

Printed Name: _____

Date: _____