Vascular Surgical Associates P.C.

Authorization for Release of Information

MEDIA RELEASE FORM

I authorize Vascular Surgical Associates, P.C. to disclose to media representatives and/or public affairs/relations representatives protected health information and information about me, my identity, my testimonial, my condition or treatment for purposes of publications, fundraising, advertising, marketing, education/research programs, publicity, promotion, education or publication in print, broadcast and electronic media, including social media. This authorization includes permission to use my likeness in a photograph, videotape and/or any other electronic or media medium inclusive of digital media and social media platforms, without payment or any other consideration.

I understand and agree these materials will become the property of Vascular Surgical Associates, P.C. and will not be returned.

I hereby irrevocably authorize Vascular Surgical Associates, P.C. to edit, alter, copy, exhibit, publish or distribute this photo/video for purposes of publicizing Vascular Surgical Associates, P.C. programs or for any other lawful purpose. This authorization waives the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness appears. Additionally, I waive the right to any royalties or other compensation arising or related to the use of the photo and/or video or other personal health information.

I hereby hold harmless, release, and forever discharge Vascular Surgical Associates, P.C. from any and all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators or other persons acting on my behalf or on behalf of my estate, have or may have by reason of this authorization. I understand and agree that this Authorization is valid for 10 years unless I cancel it in writing (as described in the next sentence). I understand that I may cancel this Authorization at any time by contacting Vascular Surgical Associates, P.C. 61 Whitcher Street Suite 2100 Marietta GA 30060. I understand that once my health information is used or disclosed, it is no longer protected by state or federal law. I also understand that revocation of this Authorization will not affect any action Vascular Surgical Associates, P.C. took in reliance on this Authorization before receiving your revocation, and any photographs and/or video previously published will not be subject to the revocation of Authorization once published.

I understand that Vascular Surgical Associates, P.C. cannot make me sign this Authorization as a condition for getting treatment, accessing medical records, or making payments on any bills unless Federal Privacy Regulations allow it.

I am 18 years of age or older and am competent to contract in my own name. I have read this release before signing below and I fully understand the contents, meaning, and impact of this release.

I understand that I am entitled to a signed copy of this Authorization.

_____	_____
Name of Individual	Street Address
_____	_____
Date of Birth	City, State, ZIP Code
_____	_____
Signature of Individual, Guardian or Representative	Email Address
_____	_____
Representative's Relationship to Individual	Signature of Employee Witness

Vascular Surgical Associates P.C.

VSA Vein Center

VSA Prosthetics Center

VSA Wound 360