PATIENT AUTHORIZATION & RELEASE
FOR MEDIA PURPOSE

I hereby authorize the use and disclosure of my image, voice, comments and/or description of the medical condition for which I am being treated, ***by Texas Oncology, P.A.*** **and Texas Oncology Foundation**, for use in internal communications, external advertising and public-relations printed materials, videos and other electronic media, press releases or Web site content.

I agree to waive all rights to the use of my image, voice or comments for the purpose intended, including any right to inspect or approve the finished product or products and the advertising copy or other matter that may be used in connection therewith, or the use to which it may be applied.

I hereby release, discharge, and agree to save harmless photographer or other professionals, his/her legal representatives or assigns, and all persons acting under his/her permission or authority or those for whom he/she is acting, from any liability of any blurring, distortion, alteration, optical illusion, or use in composite form, whether intentional or otherwise, that may occur or be produced in the taking of said picture or in any subsequent processing thereof, as well as any publication thereof, including without limitation any claims for libel or invasion of privacy.

I understand that the information used or disclosed to internal and external parties pursuant to this authorization may be subject to re-disclosure by the recipient, and that it may no longer be protected by federal or state privacy laws. I voluntarily sign this authorization, and I understand that my ability to obtain health care from this facility will not be affected if I refuse to sign this authorization.

I understand that I may revoke this authorization at any time by notifying Texas Oncology, P.A. in writing and that my revocation is not effective to the extent that the persons involved in producing/publishing my information have acted in reliance upon this authorization.

Expiration Date of Authorization: _____	***State date on which authorization for use or disclosure expires. Should an actual date not be specified, this form will remain in effect for five years from date of signature.***

Printed Name **Phone** **Practice Name/Location**

Signature of Patient or Legal Representative **Date**

If signed by legal representative on behalf of the patient, please complete the following:

Name of Legal Representative **Relationship to Patient**

Original: Medical Record Copy: Patient or personal representative