AUTHORIZATION FOR RELEASE
FOR MEDIA OR EDUCATIONAL PURPOSES

I authorize General Surgery Associates to use, release and/or disclose images, photographs, still or motion pictures or video, interviews or other media formats (information) of __________________________ to:

General Surgery Associates or other person/entities.

Information and/or images to be released (disclosed) may be used in all these formats:

- **Web site**
- **Social Media**
- **Brochures**
- **Medical Education**
- **Publicity, promotion**
- **Newspapers, journals, magazines, newsletters**
- **Professional Journals & Medical Books**
- **Broadcast News/Stories**
- **Displays**
- **Advertising**
- **Other:____________**

I understand User may take and publish or use such information for professional journals and medical books, news stories, for (patient/model) promotion, publicity, advertising, medical education, or for any other purposes which may be deemed fit.

I wave all rights that I (patient/model) may have for any claims for payment of any kind, including but not limited to royalties in connection with any exhibition, publication, televising or any other use regardless of whether such exhibition, publication, televising, or other use was under philanthropic, commercial, institutional, or private sponsorship and irrespective of whether a fee of admission or rental is charged.

I further authorize, the use of my (patient's/model's) name in connection with any publication or use of such media formats as necessary.

I do specifically agree to release, discharge and hold harmless General Surgery Associates, its staff, employees, and agents from any and all liability and responsibility arising out of or in any way connected with the publication or any use of all or any part of such media or education information, information released and/or disclosed other than for that for federally protected information pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by this rule.

I understand that I may revoke this authorization at any time by submitting a written request to General Surgery Associates, however to the extent that action has already been taken, a revocation may not be possible. I understand that General Surgery Associates cannot control the re-disclosure by the User of the information disclosed to them, provided, however that Alcohol, Chemical and Drug Abuse information which is disclosed will be accompanied by a written statement as required by law prohibiting further disclosure except as allowed by law.

I (patient/model) consider a photocopy of this authorization to be as valid as the original.

Future treatment or payment will not be conditioned by signing or not signing of this authorization. Authorization must be signed by the patient/model or legal guardian of the patient/model, or other authorized representative. If the patient/model is unable to give authorization, or physically sign, state reason:
____.

____

Patient or person authorized to sign for patient/relationship Date/Time

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Model or person authorized to sign for model Date/Time

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Witness to Signature Only Date/Time