Patient / Authorized Representative Authorization for Release of certain Protected Heath Information

By signing this authorization ("Authorization"), I hereby agree as follows:

1. I grant Goggans Associates of North Carolina, P.C. ("Practice"), acting through the Practice's employees, agents, contractors, or business associates, the right to use, disclose, and publish certain protected health information ("PHI"), including but not limited to my name, biographical information, voice, photograph, video, and/or likeness, including that which is contained within or related to any patient testimonial, including any such testimonial that I may post on social media or review websites (collectively, the "Information"), for the purposes of marketing, public relations, professional consultations, research, education, or publication in professional journals. Any such Information disclosure made by the Practice may be made available to the general public through the posting of the Information on the Practice's websites, social media pages, and through printed advertisements, television, radio announcements, and other promotional publications of the Practice.

2. I understand that the Practice may use the Information for the purposes outlined in this document and that this may benefit the Practice. I further understand that the Practice does not, and will not ever, owe me any royalty or other amount relating to use of the Information.

3. I understand that I have no right to inspect or approve of any printed or electronic matter that may be used as described herein and that the matter and materials in which my Information is used may be modified, edited, or combined with other materials. I further understand and agree that the Practice will retain the exclusive right to approve or disapprove of the extent, format, and manner in which my Information may be released. I understand and agree that the Practice will not be liable for any publication or broadcast errors.

4. I understand that entering into this Authorization is voluntary, that I may refuse to sign this Authorization, and that the Practice will not condition the commencement or continuation of treatment on my decision as to whether to provide this Authorization, nor would my refusal to sign this Authorization affect any payment, enrollment or eligibility for benefits from any source. I further understand that I may revoke this Authorization at any time after signing it by providing written notice that I would like to revoke this Authorization to the Practice at:

Goggans Associates of North Carolina, P.C.
295 SE Inner Loop
Georgetown, TX 78626

5. I understand that my grant of rights to the Practice contained in this Authorization cannot be revoked to the extent that action has already been taken in reliance on this Authorization prior to the date that the Practice receives my written request to revoke this Authorization. This Authorization shall expire ten (10) years from the date of my signature unless I terminate my grant of rights to the Practice contained herein earlier. Such termination of rights shall be on a prospective basis from and after the day on which my revocation is received by the Privacy Officer noted above.

6. I understand that the Practice will not use or disclose my PHI for the reasons set forth herein beyond the scope of this Authorization without my written consent/authorization or as otherwise permitted or required by applicable law. I further understand that disclosed Information may be subject to re-disclosure by the recipient, including any member of the public, and any such re-disclosure shall not require additional consent on my part.

7. I hereby waive, authorize, discharge and agree to hold harmless the Practice and its employees, agents, contractors, or business associates and their respective officers, directors, employees, agents, successors, and assigns and anyone authorized by any of them from any and all losses, damages, costs, expenses, rights, claims, demands, liability and actions, that may result from any use of the Information, including any distortion of my likeness, that may occur in the taking, processing, reproduction, publication or distribution of my Information, including without limitation from any claim for libel, slander, defamation, invasion of right privacy/publicity, false light or any other claim arising from or relating to the exercise of rights granted hereunder.

8. If this Authorization is signed by the authorized representative of the patient and/or dependent child, the terms "I," "me," and "my," shall be interpreted to apply to the patient, as applicable.

By signing below, I authorize the use or disclosure of the Information, including PHI, as described above, and acknowledge that I have read and accept all of the terms set forth in this Authorization.
All of my questions about this Authorization have been answered in full.