The Thrive Clinic LLC

# PATIENT AUTHORIZATION AND CONSENT FOR RELEASE OF TESTIMONIAL

Patient Name (print): _____

Date of Birth: _____

By signing this Authorization Form ("Authorization"), I understand that I am giving my authorization to The Thrive Clinic, located at 1755 NW Kings Blvd., Corvallis, OR, 97330, its employees, designees, agents, independent contractors, legal representatives, successors, and assigns ("Practice") to use my patient testimonial, or any part thereof, in advertising or other promotional materials relating to the Practice. I understand that by doing so, I am authorizing the release of my protected health information by Practice for marketing purposes. Said release shall be limited to my name and the statement that I provided below.

By signing this Authorization, I waive any right to royalties or other compensation arising from or related to the use of my patient testimonial.

I understand that my refusal to sign this Authorization will have no effect on the medical treatment I receive from Practice.

I hereby hold harmless and release Practice from all claims, demands and causes of action which I, my heirs, representatives, executors, administrators or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this Authorization.

**Right to Revoke:** I have the right to revoke this authorization at any time by providing written notice of my revocation to the contact person listed below:

The Thrive Clinic LLC
1755 NW Kings Blvd.
Corvallis, OR, 97330
Attn: Shawna Hagerman

Please understand that revocation of this Authorization will not affect any action Practice took in reliance on this Authorization before receiving my revocation.

**Information to be Disclosed:** I hereby authorize the following statement to be attributed to me in advertising or promotional materials of Practice:

_____

_____

_____

_____

_____

**<u>Purpose for Disclosure</u>:** At the request of Practice.

Unless earlier revoked, this Authorization will expire on ____/____/____.

If neither federal nor state privacy laws apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or state privacy law.

**I grant this consent as a voluntary contribution and certify that I have read the above Patient Authorization and Consent for Release of Testimonial and fully understand its terms.**

_____ _____

Signature of Patient Date

_____ _____

Signature of Patient's Representative (*if applicable*) Date

_____

Printed name of Patient's Representative *(if applicable)*

_____

Relationship to patient *(if applicable)*