604 Corporate Dr W
Langhorne, PA 19047
(215) 490-0000

POLICY / PROCEDURE for obtaining Authorization and Consent to Disclose Protected Health Information for Marketing and Promotional Purposes

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PURPOSE: The purpose of this policy is to establish guidelines to obtain and document the required authorization and/or release to photograph, interview, videotape, or otherwise record current and former patients, family members, employees or other individuals (hereinafter "Subject") in compliance with HIPAA and applicable privacy laws.

POLICY STATEMENT: Ahimsa Therapeutics must obtain a written Release from every Subject prior to the Subject's participation in any marketing or PR campaign, and any external news or media story, involving photographs, interviews, videotapes, or other recording. In addition to the Release, if the Subject is a patient, a patient's family member, or other individual involved in a patient's care or treatment, a Patient Authorization form must be completed by the patient, or patient's personal representative, as appropriate, authorizing the use or disclosure of the patient's Protected Health Information as part of the marketing or PR campaign, or in connection with an external news or media story.

Ahimsa Therapeutics assumes no liability for the use of any photographs, interviews, videotapes, or recordings. The Subject providing the Release waives all rights to claims for payment in connection with any use of the photographs, interview material, videotape, or other recording.

PROCEDURE: Before photographing, videotaping or recording a patient's or patients' family member or other individual in connection with the patient's treatment [hereinafter "Subject(s)], Ahimsa Therapeutics shall:

1. Explain the purpose of the requested release of the patient's photographs, videotapes, recordings and/or associated protected health information to the Subject(s).
2. Inform the Subject(s) that participation and authorization is voluntary and that treatment will not be conditioned on the Subject's agreement to participate.
3. Obtain the Subject's agreement and signature on the **HIPAA Authorization for Use and Disclosure of PHI for Marketing and/or Promotional Purposes**
4. Obtain the Subject's signature on the **Consent for Use and Disclosure of Image, Voice, and/or Written Testimonials** form. (You must use *both forms.)*
5. If the request involves participation by individuals other than the patient (e.g. as in the case of a recorded testimonial from a patient and a patient's family member), a separate Release form must also be obtained from any other individual who will participate in the photograph, interview, videotape, or other recording.

HIPAA Authorization for Use and Disclosure of PHI for

Marketing and/or Promotional Purposes

I, _____, authorize Ahimsa Therapeutics and its employees, agents, and authorized representatives, to use and/or disclose my Protected Health Information contained in any photographs, videos, medical and physical therapy records, and/or audio recordings for the following purposes:

- ❑ Use in internal and external advertising, marketing, public relations or collateral materials, including but not limited to posting on Ahimsa Therapeutics' website and social media sites.
- ❑ Use in news releases or stories, including television, newspaper, or radio broadcasts.
- ❑ Use in internal and external education and/or training programs for the public and/or medical professionals, including but not limited to use on public websites and social media sites.

I further authorize Ahimsa Therapeutics to use and/or disclose the following information personal information in conjunction with the use/disclosure of my photographs, videos and/or audio recordings:

- ❑ My name
- ❑ My demographic information
- ❑ Information about my diagnosis, physical therapy problems, basic treatment information, or other personal information necessary to accomplish the purpose of the marketing/promotional effort, except as specifically described as follows (please describe if applicable):_____
  _____
  .

I provide my authorization knowing that:

- The Protected Health Information that is used or disclosed pursuant to this authorization, including Protected Health Information contained in any photographs, videotapes, or interviews, may be subject to re-disclosure by the recipient(s) and may no longer be protected by HIPAA or other state or federal laws.
- Signing this authorization is voluntary. I have the right to refuse to sign this authorization.
- My treatment, payment, enrollment in a health plan, or eligibility for benefits is not conditioned on my provision of this authorization.
- I understand that I can revoke or cancel this authorization at any time by sending written notice to:

Ahimsa Therapeutics
Attn: Amy Morris M.S., P. T.
429 Taylor Avenue
Newtown PA, 18940

- If I revoke or cancel this authorization, I understand that the revocation will not apply to Protected Health Information that has already been used or disclosed in reliance on my authorization.
- I am entitled to receive a copy of this Authorization upon request.

Unless I revoke this authorization, it will expire 30 months from the date signed below.

Patient Name (Print): _____

Patient Signature: _____

Date: _____

Legal Representative (Print name, if applicable): _____

Legal Representative Signature: _____

Date: _____

Legal Representatives Relationship to Patient (if applicable): _____

Consent and Release for Use and Disclosure of Image, Voice, and/or Written Testimonials

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I, _____ consent to the photographing, recording and unlimited use of my likeness (including my name, voice and/or image) for commercial, promotional or other use, in any medium, by Ahimsa Therapeutics and its employees, affiliates, subsidiaries, licensees, successors, and assigns. I waive all rights of attribution, inspection, or approval for any use of my likeness. Ahimsa Therapeutics and its employees, affiliates, subsidiaries, licensees, successors, and assigns are held expressly harmless for any liability, legal and/or financial, incurred as a result of said use. I waive any right to royalties or other compensation arising from or related to the use of my likeness. All right, title, and interest to any photographs, recordings, and any other materials using my likeness shall be the sole property of Ahimsa Therapeutics. I shall have no interest in any such materials nor shall I have any right to use the name or trademarks of Ahimsa Therapeutics without its express, written permission.

I HEREBY ACKNOWLEDGE THAT AHIMSA THERAPEUTICS OR ANY OF ITS AGENTS OR EMPLOYEES HAVE NOT MADE ANY REPRESENTATIONS OR WARRANTIES OF ANY KIND WITH RESPECT TO ANY MEDICAL OR OTHER ADVICE OR INFORMATION THAT I MAY RECEIVE IN CONNECTION WITH MY APPEARANCE AND THAT I HAVE NOT RELIED ON ANY SUCH REPRESENTATIONS OR WARRANTIES IN AGREEING TO PARTICIPATE IN THE RECORDING OF MY VOICE AND/OR LIKENESS AS DESCRIBED ABOVE OR IN THE EXECUTION OF THIS CONSENT FOR USE AND DISCLOSURE OF IMAGE, VOICE AND/OR WRITTEN TESTIMONIALS (THE “CONSENT”).

I am signing this Consent and Release voluntarily, having read it in its entirety and understanding the contents thereof to my satisfaction, and I acknowledge that it is binding upon me, my legal representatives, heirs and assigns. I understand that this Consent will be signed contemporaneously with the form entitled Authorization for Use and Disclosure of Protected Health Information for Marketing and Promotional Purposes (the “Authorization”), and I agree that in the event of conflict between the two documents, the terms of the Authorization shall govern.

Printed Name: _____

Signature: _____

Date: _____