THE CARDIOVASCULAR CENTER OF FLORIDA

Authorization to Release Health Information Pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

I, or my authorized representative, authorize(s) **The Cardiovascular Center of Florida** located at **1723 Lucerne Terrace, Suite 100 Orlando, FL 32806** ("**CVCFL**") to use and disclose my personal information and health information, including my name, age, image, photo, video, and patient status and treatment information ("Information") to:

All viewers of certain promotional photos, videos, or other media in The Cardiovascular Center of Florida and its affiliates' marketing materials, publications, and communications and on The Cardiovascular Center of Florida and its affiliates' website and social media sites.

The Information is being used and/or disclosed for the following purposes: Certain promotional and marketing photos, videos, or other media on **The Cardiovascular Center of Florida** and its affiliates' website or social media sites for which disclosure of my Information will result in payment and other remuneration to **The Cardiovascular Center of Florida**; and certain promotional and marketing materials, publications and communications for which marketing communications **The Cardiovascular Center of Florida** may also receive financial remuneration.

I understand that my Information may be disclosed through photography, filming, videotaping and/or audio recording, or other means of capturing my Information and/or being quoted in the media or printed materials (including social media websites).

This Authorization expires upon the completion of **The Cardiovascular Center of Florida's** publicity/ marketing campaign.

I understand that signing this Authorization is voluntary. My treatment, payment, health plan enrollment, or benefits eligibility will not be conditioned upon my authorization of this use and/or disclosure. I have the right to revoke this Authorization in writing by sending a written notification to **The Cardiovascular Center of Florida** at the above address. I understand that a revocation is not effective to the extent that action has already been taken based on this Authorization. I understand that the Information disclosed under this Authorization might be re-disclosed by the recipient and will no longer be protected by HIPAA and its implementing regulations. I understand that I have the right to receive a copy of this Authorization.

_____
Printed Name of Patient or Personal Representative

_____
Patient DOB

_____
Signature of Patient or Personal Representative

_____
Signature Date

_____
Description of Personal Representative's Authority to Sign for Patient