BAGSHAHI
BARIATRIC AND GENERAL SURGERY

Consent for Photography

I, _____ *(the undersigned)*, hereby give my consent to HB Health to:

[ ] Take photographs (Before & After)

Authorization for Use and Disclosure

I hereby authorize HB Health to use and disclose the health information/images consented to above and relating to treatment I received during the following time period

_____.

HB Health may use or disclose these images/ health information for the following purposes (check all that apply):

[ ] HB Health publications
[ ] HB Health website(s)
[ ] News media stories
[ ] Multimedia file distribution (photo, video, podcast or digital file for distribution over the Internet and social media such as YouTube, Facebook, Twitter)
[ ] Other HB Health digital or electronic advertising, marketing, promotions or events
[ ] Radio or TV commercials
[ ] Other media produced by third parties in cooperation with HB Health

Subject to the following limitations: _____

_____

This authorization expires: _____ (*enter date*).

Restrictions

Law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law.

Your Rights

- You may refuse to sign this authorization and your refusal will not affect your ability to obtain the best medical care in Texas from HB HEALTH.

- You may revoke this authorization at any time. Your revocation must be in writing, signed by you or someone on your behalf, and delivered to this address:

  HB Health, **Attn: Practice Manager, 800 5th Ave., Fort Worth, TX 76104**

- Your revocation will be effective upon receipt, but will have no impact on uses or disclosures made while your authorization was valid.
- You have a right to receive a copy of this authorization.
  To request a copy, please email info@hbhealth.care

SIGNATURE

_____ _____ _____ AM / PM

Signature (Patient/Representative) Date Time

Address/Phone/Email (optional): _____

If signed by other than patient, print name and relationship:

_____ _____

Name Relationship

_____ _____ _____ AM / PM

Witness Date Time

(Witness only required for telephone consent, physical inability to sign, or signature by mark)