PUBLICITY RELEASE
AND
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Birth Date: _____
Address: _____
_____

I hereby authorize Where the Garden Grows Medical Clinic and Drs. Karen Prentice, Kristin Shepherd and (collectively and individually, the **"Practice"**) to use and disclose:

My child's first name and last name, picture, age, city/state of residence, other identifying information, and information about their medical condition and treatment at the Practice (including information that is "protected health information" under HIPAA);

For the purpose of:

Advertising and marketing about the Practice, and for other stories, articles and/or interviews relating to medical topics.

Books written by Dr. Karen Prentice, including "An Apple a Day the Doctor's Way."

I authorize the Practice to use and publish this information on its website, in its in-office advertising, in its company newsletters and brochures and in any and all forms and media now known or later developed. I also authorize the Practice to use and disclose this information with and to advertising agencies, internet providers, magazines, newspapers, radio stations, and/or TV stations (including cable TV and internet TV), book publishers, other media companies and the public.

I further waive any and all rights to review or approve any uses of the information described above, including, but not limited to, any images, any written copy or finished product.

Unless revoked earlier, this Authorization will expire on _____.
(Insert a Date, Event, or "Never")

I understand that I may revoke this authorization at any time, except to the extent action has been taken in reliance upon this Authorization. Revocation of this Authorization must be made in writing to the Practice, at 7757 W. Deer Valley Rd. Suite 275 Peoria, AZ. 85382 Attention: Office Manager, or via fax to 623-930-4822.

I understand that once the information described above is used or disclosed by the Practice, it may be re-used and re-disclosed by recipients, and may no longer be protected by federal and state law.

I understand that I will not receive any compensation by reason of this Authorization. I hereby grant the Practice a royalty-free, non-exclusive, sub licensable, assignable worldwide license to use and disclose the information as described above.

I understand that the Practice may not condition treatment on whether I sign this Authorization.

I ☐ **do** ☐ **do not** authorize the release of this type of information.

_____ _____
Parent or Legal Guardian Signature Date