CONSENT TO USE OF LIKENESS AND TESTIMONIAL AND RELEASE

I, _____, hereby consent to allow _____, and its employees, agents, partners, and affiliates (collectively "Clinic"), to use my name, photograph, videotape/audiotape recording, and/or written testimonial ("Marketing Materials") in Clinic's marketing brochures, publications, and/or on their website and any social media accounts to promote the services offered by Clinic. I understand and agree that these Marketing Materials are owned by Clinic and will not be returned to me.

I hereby release, hold harmless, and forever discharge the Clinic from any and all claims, demands, and causes of action which I have or may have by reason of this authorization.

Further, I hereby affirm that I have read this Consent to Likeness and Release, and I fully understand the content, meaning, and impact of this agreement. This agreement shall be binding upon me and my heirs, legal representatives and assigns.

_____ _____
Patient Signature Date

_____
Parent/Legal Guardian (If Patient is a Minor)

HIPAA AUTHORIZATION FOR DISCLOSURE OF PHI

I, _____, hereby consent and authorize Life Fitness Physical Therapy LLC, and its employees, agents, partners, and affiliates (collectively "Clinic") to disclose my Protected Health Information ("PHI"), as that term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for marketing purposes, as stated below. I understand that subsequent disclosures by recipients of my PHI may not be protected by the HIPAA Privacy Rule or other applicable medical record privacy laws.

I authorize Clinic to disclose my PHI, in the form of written statements, photographs, and videotape/audiotape recordings, in the Clinic's marketing brochures, publications, and/or on their website and any social media accounts for purposes of promoting and advertising Clinic's services.

I understand that I may revoke this authorization at any time by giving written notice to Clinic, except to the extent that Clinic and its agents, employees, and representatives may have taken action in reliance on this authorization.

This authorization is effective on the date stated below for an indefinite period of time. A photocopy of this authorization form is valid and should be given the same force and effect as the original.

_____ _____
Patient Signature Date

_____
Parent/Legal Guardian (If Patient is a Minor)