the allergy station
Travis A Miller MD
1478 Stone Point Drive Suite 290
Roseville, CA 95661

PHOTO, INTERVIEW AND MEDIA CONSENT FORM

Authorization for Use and Disclosure of Protected Health Information
Please complete the following information:

Patient/Visitor Name: _____ Date of Birth: _____

I hereby authorize The Allergy Station and its affiliates and agents to take photographs, videotapes, audiotapes, electronic files, or other types of media that capture my name, voice and/or image, to be released or used by The Allergy Station for the purpose of:

- News media (online, print and/or broadcast)
- Publications and/or promotional materials
- Closed-circuit television programs
- Advertisements
- Websites and social media
- Medical and/or educational training
- Any other lawful purpose

The information to be disclosed includes (check all that apply):

- ☐ Photographic images of me
- ☐ Video or audio of me and/or my voice
- ☐ Images from records such as scans and/or X-rays
- ☐ Information about my medical condition and/or prognosis
- ☐ Information about date(s), time(s) and type(s) of treatment received
- ☐ Other _____

I understand that this authorization is voluntary, without compensation, and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment. I understand by signing this form I represent and warrant that I have authority to sign this document, authorize the use or disclosure of protected health information and declare there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

This authorization shall remain in effect for 12 months from the date below and shall automatically renew for additional one year periods until such time as you notify The Allergy Station of your intent to revoke this authorization. You may provide such notice by sending your written request to The Allergy Station, 1478 Stone Point Dr. Suite 290, Roseville, CA. 95661

_____ _____
Signature of patient/visitor or patient's/visitor's legal representative Date

_____
Printed name of patient/visitor or representative

If signing as a representative, please indicate your relationship to the patient/visitor:

☐ Parent ☐ Guardian ☐ Power of attorney

This portion is to be completed by a representative of The Allergy Station.

_____
Signature of The Allergy Station representative

_____
Date

_____
The Allergy Station employee name

Purpose of photo and/or interview (provide details):