ASSISTED INDEPENDENCE, LLC.
www.assistedindependence.care P.O. Box 1683, Columbus, IN 47202 812-374-9450

AUTHORIZATION FOR RELEASE OF PHOTO, VIDEO, OR STORY
PURSUANT TO 45 CFR 164.508 HIPAA

To: Assisted Independence, LLC.**,** (the "Covered Entity") You are hereby authorized to release the following information and records in your possession concerning **[individual]** _____to Assisted Independence, LLC., who is also authorized to release the following information and records in possession to healthcare professionals concerning the care of the individual.

☐ Pictures, videos and or stories of the individual for the use of educational purposes, marketing purposes across all platforms, including, but not limited to, website publication, social media postings, flyer, brochure, or rack cards printing and distribution.

☐ Permission to use my only first name on pictures, videos and or stories for the use of educational purposes, marketing purposes across all platforms, including, but not limited to, website publication, social media postings, flyer, brochure, or rack cards printing and distribution.

☐ Permission to tag my social media page in the event a picture(s), video(s) and or story(ies) is shared on a company social media platforms, including, but not limited to, FaceBook, LinkedIn, Instagram, or X.

If yes, your social media page platform URL or Handle (@Example): _____

☐ Other: _____

Name: _____ D.O.B: _____

This authorization is given in compliance with 42 CFR § 164.508. This information is requested for the purpose of facilitating community-based habilitation, participant assistance and care, respite care, recreational therapy, and/or residential habilitation and support to be provided to the individual by Assisted Independence, LLC. You are authorized to discuss with Assisted Independence, LLC all matters concerning the medical treatment, condition, prognosis, and the records that are being requested. Please do not discuss or disclose such information to any person(s) without written authorization from me. This Authorization shall remain valid until revoked by me in writing and revokes all prior authorizations for release of information. A photocopy of this Authorization shall be deemed the same as one bearing my original signature. I understand that I may revoke this authorization at any time by providing written notice to the Covered Entity, except to the extent the Covered Entity has taken action in reliance on this Authorization or if this Authorization was obtained as a condition of obtaining insurance coverage other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Individual or Individual's Representative Signature: _____ Date: _____

Printed: _____ Relationship: [guardian, parent]: _____

All portions of this form must be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be not be considered.

(Rev. 12/20/2023) Valid one (1) year from signature date

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Assisted Independence

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