Authorization for the Use and Disclosure of Protected Health Information

I authorize Melissa A. Crosby, MD, FACS and/or Melissa A. Crosby, MD PLLC to use and disclose my photographs, video, audio recordings, radiologic images, and/or treatment history (PHI) to the public for educational purposes (both in person and online), including presentation at a scientific conference, forum, workshop, or seminar, and/or publication in a printed or electronic scientific journal, textbook, or educational website.

_____ (initial) I also authorize the use of my photos in the Photo Gallery on the Melissa A. Crosby, MD PLLC Website.

My name will not be disclosed; however, I understand that in some circumstances, images/photographs used may be recognizable.

I understand that once my PHI is shared, if the person receiving my PHI is not a health care provider or health plan, my PHI may not be protected by federal privacy laws anymore.

This authorization is optional and I do not have to sign it. If I don't sign, my treatment, payment, and eligibility for benefits will not be affected.

This authorization may be revoked at any time by sending a written request to Melissa A. Crosby, MD PLLC, 16605 Southwest Freeway, Suite 300, Sugar Land, Texas 77479. If revoked, no further PHI will be shared, but anything, but anything already shared may stay public.

This authorization has no expiration date.

Signature of Patient or Legally Authorized Rep.: _____

Printed Name: _____ Date: _____

Legally Authorized Representative's Authority (check all that apply): ____ Parent ____ Guardian

_____ Legal Next of Kin (if patient is deceased) ____ Other (specify): _____

Melissa A. Crosby, MD PLLC STAFF USE ONLY

Employee Name/Recipient: _____

A copy of the completed form must be provided to the signing individual. The original must be included in the medical record.