Gilvydis Vein Clinic

GENEVA • NAPERVILLE • SYCAMORE • ROCKFORD

AUTHORIZATION FORM

I hereby authorize Gilvydis Vein Clinic (GVC), including its physicians, nurses, staff, and other employees, to use my name, photograph(s), and video taken of me, and written statements provided by me on its social media platforms, solely for the purpose of creating and publishing marketing materials and/or ads about my treatment experience and results as a Gilvydis Vein Clinic patient (any of which are referred to herein as my testimonials, treatment results, and experience.) I hereby authorize Gilvydis Vein Clinic to use and publish my testimony in or on GVC-associated printed materials, photos, videos, publications, social media platforms, website, and any other form of media or form of communication now existing or hereafter developed. I acknowledge and agree that the information described above may be received by or viewed by members of the general public, as well as current and future patients of GVC.

I have voluntarily chosen to provide or allow for the use or disclosure by Gilvydis Vein Clinic of the following vein health information. I understand that Gilvydis Vein Clinic uses this information to demonstrate how vein treatments can change and transform the quality of life of people who have vein disease and understand that I will not receive compensation for the use of this information. Gilvydis Vein Clinic may use these materials for marketing their services, and show their positive clinical outcomes.

Please initial all of those that apply:

____ Written or Verbal Testimonials, Comments or Quotes (first name only or initials)
____ Name/Treatment Status/Location
____ Before/After Photograph(s)/Likeness
____ Audio Recordings (either recorded in private or during a public presentation for example during an Event / Class/ provider session)
____ Video Recordings

I understand that I may revoke this Authorization at any time by notifying the Privacy Office of Gilvydis Vein Clinic in writing. If I revoke this Authorization, Gilvydis Vein Clinic will not make any new use or publication of the information described above but my revocation will not have any effect on actions taken and information published or disseminated prior to my revocation. I understand that information disclosed pursuant to this Authorization may be redisclosed by the recipient and may no longer be protected by federal privacy regulations. This Authorization expires upon the earlier of my revocation of this Authorization or ten (10) years from the date of my execution of this Authorization. I understand that I do not have to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from GVC, nor will it affect my eligibility to obtain payment for such health care.

_____
Print Name

_____ Date: _____
Patient Signature

_____ _____
Phone E-Mail

_____ Date: _____
Signature of Witness