1. Introduction and Purpose

This HIPAA Release and Testimonial Consent Form ("Form") is executed in the State of Georgia and is intended to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as well as applicable Georgia state privacy laws. By signing this Form, the Patient authorizes NuBalance Health, its agents, and affiliates ("Authorized Releasee") to use and disclose Protected Health Information (PHI) specifically for testimonial and marketing purposes, including use on social media and promotional platforms.

Signing this Form is voluntary and not a condition for receiving treatment or healthcare services.

2. Definition of Confidential Information

"Confidential Information" means all identifiable information related to the Patient's health condition, medical history, treatments, medications, and any likeness (e.g., name, photograph, video, voice) that may be considered PHI under HIPAA.

Confidential Information does not include information that is:

- Publicly available at the time of disclosure;
- Rightfully obtained from a third party without breach;
- Independently developed without reference to PHI;
- Disclosed with the Patient's unrestricted consent.

3. Scope of the Release

This Form authorizes NuBalance Health to use:

- The Patient's testimonial (written, audio, or video);
- The Patient's name, image, and likeness;
- Medical experiences relevant to the testimonial;
- Medication or treatment details directly referenced in the testimonial;
- Social media handle (if voluntarily provided).

This information may be used solely for marketing, social media, website, and outreach materials by

NuBalance Health.

4. Duration of Release

This Form is valid for 2 years from the date of signature, unless revoked earlier in writing by the Patient.

5. Right to Revoke

The Patient may revoke this authorization at any time by submitting a written notice to:

NuBalance Health
[Insert Clinic Address]
Email: [Insert Clinic Email]

Such revocation will not affect any use or disclosure that has already occurred based on this consent.

6. Media Release

By signing this Form, the Patient grants NuBalance Health the right to publish their testimonial and image/likeness in any format (photo, video, audio) for marketing purposes. This includes permission to edit or modify the media and to use the Patient's name unless the Patient requests anonymity in writing.

The Patient agrees that:
- No compensation will be provided;
- They waive the right to review or approve final media;
- This consent does not impact their healthcare services in any way.

7. HIPAA Compliance

NuBalance Health agrees to:
- Use and disclose PHI solely for authorized purposes;
- Protect PHI from unauthorized access;

- Notify the Patient in the event of any data breach;
- Require all agents, contractors, or media vendors to maintain confidentiality.

8. Governing Law

This Form shall be governed by and interpreted in accordance with the laws of the State of Georgia. Any disputes shall be resolved in courts within the State of Georgia.

9. Acknowledgment and Signature

By signing below, the Patient confirms:

- They understand and voluntarily agree to the terms of this consent;
- They allow NuBalance Health to use their testimonial and PHI as described;
- They have the right to request a copy of this completed form.

Patient Signature: _____

Printed Name: _____

Date: _____

If Patient is a Minor or Incapable of Signing:

Representative Name: _____

Relationship to Patient: _____

Signature of Representative: _____