Part B Insider (Multispecialty) Coding Alert

Check Out This Sample Social Media Testimonial Authorization

If your HIPAA compliance stops with the standard form you printed off the internet, you could be selling yourself short. Check out the following form authorizing social media testimonials created by said **Paul Hales, Esq.,** a healthcare attorney in St. Louis, MO, which he includes in his HIPAA E-Tool:

Dr. Smith
Authorization for Testimonials - Social Media

Date: _____

Name of Patient:_____

Date of Birth:_____

Last 4 numbers of SSN: XXX-XX- _____ _____ _____ _____

Address: _____

We very much appreciate the fact that you are pleased with your experience at Dr. Smith and Associates and wish to provide a testimonial expressing satisfaction with your experience. Your testimonial may be posted on our website, used in social media or printed materials and may be released to the media. Please understand that a testimonial may involve the use or disclosure of information that is protected by health privacy law. In order for you to make a testimonial you must authorize the use or disclosure of information about you in your testimonial. You may use this form to provide the necessary authorization.

Authorization:

I hereby authorize the use and disclosure of information I describe in this form for testimonial purposes by Dr. Smith. My authorization to use my information extends to any persons and agents working on behalf of Dr. Smith to create or maintain materials in any format that may include my testimonial including but not limited to printed materials, websites and social media.

1. Description of the information to be used or disclosed in my testimonial:

Please describe the information that will be in your testimonial - for example, your name, picture, a video of you talking about your experience, etc. - in this box:

2. Name or Identification of persons to whom I authorize Dr. Smith to make the requested use or disclosure:

I authorize Dr. Smith to use my information as a testimonial for disclosure to the general public who may view or read my testimonial on materials created by or for Dr. Smith and Associates including but not limited to printed materials, websites and social media.

3. Purpose

The purpose of the requested use or disclosure is "At My Request."

4. Expiration Date of this Authorization

This authorization shall be valid - unless I revoke it earlier in writing - for ten (10) years from the date I sign it. I understand that:

1. I may revoke this authorization at any time in writing and that Dr. Smith will furnish me with a form to make my written revocation if I ask for the form but I am not required to use that form to make my written request for revocation.

2. My revocation will not apply to the information that has already been released as permitted by this authorization.

3. Dr. Smith may not condition my treatment or payment, enrollment or eligibility for benefits on whether I sign this authorization.

4. The persons to whom this information is disclosed may re-disclose the information and it will no longer be protected by federal health information privacy law.

5. I have a right to request and receive a copy of this authorization.

I have read and understand this Authorization for Testimonials - Social Media, signed it voluntarily and received a copy.

Signature of Individual or Personal Representative_____

Printed Name of Personal Representative, if any_____

Personal Representative Authority to act for the Individual (Documentation may be requested)_____

¨ **Identity of the Individual verified**

¨ **Identity and Authority to Act of Personal Representative verified**

Received and confirmed for Dr. Smith by:

_____

Signature Printed Name/Title

Resource: To review Hales' HIPAA E-Tool, visit http://thehipaaetool.com/index/contents.