Retina Macula Specialists, PLLC
660 Shoreview Avenue, Winter Park, FL 32789
100 Park Pl Blvd, Ste 202, Kissimmee, FL 34741
407-931-1510

Authorization for Use of Testimonial, Photograph, or Video

HIPAA authorization (45 CFR 164.508) · Form revised November 11, 2026

This form gives Retina Macula Specialists, PLLC ("the Practice") permission to use your words, image, or story in its marketing. You do not have to sign it, and your care will not change if you decline.

Patient

Patient name (print) _____ Date of birth _____

Phone _____ Email (optional) _____

1. What may be used (check all that apply)

☐ my written or spoken testimonial ☐ my photograph ☐ video or audio of me ☐ my first name or initials ☐ my full name
☐ a general description of my condition and treatment:

_____

2. Who may use and receive it

The Practice and the vendors who build and maintain its website and marketing materials may use it. Once published, it may be seen by anyone.

3. Where it may appear

☐ the Practice's website (rmseye.com) ☐ the Practice's social media ☐ printed materials in the office ☐ other: _____

4. Purpose

To inform the public about the Practice and its services (marketing).

5. Expiration

This authorization expires on _____ or three years from the date signed, whichever comes first.

6. Your rights

- **Right to revoke.** You may revoke this authorization at any time by writing to the Privacy Officer, Retina Macula Specialists, PLLC, 100 Park Pl Blvd, Ste 202, Kissimmee, FL 34741. Revocation will not affect material already published or distributed before the Practice receives your notice, but the Practice will remove it from the channels it controls within a reasonable time.
- **No effect on care.** Your treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether you sign this form.
- **No compensation.** You are not receiving any payment, discount, or other benefit for this authorization.
- **Redisclosure.** Once published, this information is public and may no longer be protected by federal privacy law.
- **Copy.** You have the right to receive a copy of this signed form.

Signature of patient or legal representative _____ Date _____

If signed by a representative: printed name _____

Relationship / authority (e.g., guardian, health care surrogate) _____

For office use: received by _____ on _____. File with the patient's record; calendar the expiration date.