magnes

Consent and Authorization Form (Patient)

(*Marketing / Case Study / Testimonial Use)*

1. Patient Information

Patient Name: _____
Date of Birth: _____
Address: _____
Phone (optional): _____

2. Healthcare Provider / Facility

Clinic Name: _____
Address: _____
Phone: _____

3. Description of Information to Be Used or Disclosed

I authorize the use and disclosure of the following protected health information (PHI):

- My diagnosis and medical condition (e.g., Parkinson's disease)
- Treatment information and therapy protocols
- Functional outcome measures and test results
- Photographs
- Video recordings
- Audio recordings
- Written testimonials or statements
- Other (specify): _____

I understand that:

- My image and/or testimonial may be publicly accessible.
- The clinic and/or Magnes may edit materials for clarity or formatting.
- I will not have the right to inspect or approve final materials prior to publication unless otherwise agreed in writing.

This information may include details related to my physical therapy treatment and outcomes.

4. Purpose of Disclosure

The purpose of this authorization is for:

- Marketing and promotional materials
- Educational materials
- Website publication
- Social media
- Print materials (brochures, flyers)

- Conference or trade show presentations
- Professional publications
- Other: _____

I understand that my information may be used to promote therapy services or medical devices, including materials distributed by the clinic and/or Magnes.

5. Persons / Entities Authorized to Receive Information

I authorize the disclosure of my information to:

- Clinic Name: _____
- Magnes (Switzerland) and its marketing representatives
- Third-party media or marketing vendors acting on behalf of the clinic or Magnes

6. Voluntary Authorization

- I understand that signing this authorization is voluntary.
- My treatment, payment, enrollment, or eligibility for benefits will NOT be conditioned on whether I sign this form.
- I understand that this consent is given in perpetuity, does not expire, and that it is binding.

7. Potential for Re-Disclosure

I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA privacy regulations.

8. Use of Identifiers

Please select one:

☐ I authorize the use of my full name.
☐ I authorize the use of my first name and last initial only.
☐ I authorize the use of de-identified information only.
☐ I authorize the use of my image/video without my name.

9. Signature

By signing below, I acknowledge that I have read and understand this authorization.

Patient Signature: _____
Date: _____

Media Release Statement

I grant permission for photographs, video recordings, and/or audio recordings to be used in print, digital, and electronic formats, including websites and social media platforms.

I understand that:

- My image and/or testimonial may be publicly accessible.
- The clinic and/or Magnes may edit materials for clarity or formatting.
- I will not have the right to inspect or approve final materials prior to publication unless otherwise agreed in writing.

Signature: _____
Date: _____

Name Clinician: _____
Signature: _____
Date: _____