ZF Discussion Draft
2/21/22

AUTHORIZATION TO USE AND RELEASE TESTIMONIAL AND OTHER INFORMATION FOR PROMOTING THE PRACTICE AND/OR THE AMERICAN SOCIETY OF ACUPUNCTURISTS

Patient's Name:_____ DOB:_____
Address:_____

I hereby authorize _____ **[to insert name of acupuncture practice]** (the "**Practice**") to disclose the specific information as set forth below and in accordance with this authorization.

The Practice may use and disclose the following information ("**My Testimonial Information**"): the attached testimonial, any portion of the testimonial, and any interview by the Practice with me concerning the testimonial, and/or any information derived from the testimonial or interview including but not limited to my name, address, the fact that I receive treatment and other services from the Practice and its staff.

My Testimonial Information may be used and disclosed by the Practice as follows:

(i) to the American Society of Acupuncturists (the "**ASA**"), its affiliates and agents, to use and disclose My Testimonial Information with legislators, lobbyists, policy makers, or the public, to encourage the passage of HR 4803. HR 4803 is a bill that has been introduced in the U.S. Congress, *the Acupuncture for Our Seniors Act* that would allow Licensed Acupuncturists to become recognized as Medicare providers. Upon approval of this Authorization, my Testimonial Information will be sent, without limitation, to the ASA via email at patients4acupuncture@gmail.com;

(ii) to the ASA, its affiliates and agents, for any other promotional purposes including but not limited to seeking changes in the law, changes in any payor program (private or public such as Medicare); research, and education. Such uses and disclosures may be for seeking grants, funding and other programs of any nature or description that provides loans, grants, payments or other benefits to the ASA. In no case shall I be entitled to any compensation of any nature or description in connection with My Testimonial and the uses and disclosures expressly permitted in this Authorization or as otherwise permitted by law; and

(iii) the Practice in any manner permitted for its health care operations including but not limited to promoting the Practice and/or its staff**.**

In connection with the above permitted uses and disclosures, My Testimonial Information would be used in any manner or form including, without limitation, quotes from My Testimonial Information, interview(s) with you and members of the Practice's staff (or excerpts of same), in part or in whole, in any printed, electronic or verbal format in any of the following forms: (i) letters, presentations, speeches, summaries, reports, printed articles, notices, bulletins, flyers, announcements, newsletters, promotional materials or any other printed media of any nature or description, (ii) any electronic format whether contained in electronic newsletter, separate article(s) posted on any websites or any other use of any nature or description, including, without limitation use on Social Media (including Facebook, Twitter, etc.); and (iii) discussion at any meeting, private or public event, announcement or any other use or any nature or description.

The purpose(s) of this authorization is to help promote the Practice, the ASA as well as the practice of acupuncture in seeking legislative and other changes as well as any other promotional or educational purposes.

This authorization may be revoked by me at any time except to the extent that the person(s) and/or organization(s) listed above have already acted in reliance upon this authorization. If I revoke this authorization, I need to do so in writing and mail or hand deliver it to **[inset name of practitioner or title of the person at the practice that would receive such revocations such as "Office Manager" or other title as well as address]** Or I may email my revocation to _____ and patients4acupuncture@gmail.com. Emailing to both email addresses will help ensure that not only will the Practice no longer use or disclose My Testimonial Information but that the ASA will also stop using and disclosing My Testimonial Information as well. If not revoked by me, this authorization will terminate ten (10) years from the date of this Authorization.

I understand that I may inspect and/or copy the information to be disclosed.

I understand that this authorization is voluntary. I understand that I do not need to sign this form in order to ensure continue to receive treatment from the Practice and/or any health care treatment, payment, enrollment in my health plan, or eligibility for benefits. I also understand that if I have any questions regarding the use or disclosure of my information, I may contact the privacy officer at the Practice.

Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and will no longer be protected by any contractual or other rights that may be afforded to such information including without limitation, the federal regulations protecting privacy of an individual's health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Regulations") and other applicable federal and state law.

Photocopies and facsimile copies of this Authorization shall be deemed to be originals.

Patient's Signature: Date:

_____ _____