Cascade Dafo, Inc. | 1360 Sunset Ave, Ferndale, WA 98248 | **ph:** 800.848.7332 **fax:** 360.384.4558 | **intl:** + 00 1 360 543 9306 **www.cascadedafo.com**

Media Release of Health Information

Patient Name

Street Address

City, State, Zip Code

( ) Phone

For Office Use Only

Type of Orthotic / Brace Style

Patient Presentation

Pseudoname

I hereby give my permission and authorize Cascade Dafo, Inc. / Cascade Prosthetics & Orthotics, Inc. (CASCADE) to use and disclose **photographs**, **video recordings**, and/or **audio recordings** of me, without compensation, for the following uses:

- Video (for educating practitioners on proper use of CASCADE products);
- CASCADE conference exhibits;
- Inclusion on CASCADE & CASCADE Customer websites;
- CASCADE advertisements and other print marketing materials or articles;
- CASCADE workshops (for practitioners);
- Video (for marketing purposes).

Patient - Please strike through the disclosures described above that you are <u>not</u> authorizing, if any.

Video related materials that will be used for educating practitioners on proper use of CASCADE products will emphasize gait and posture by focusing on the lower extremities. In such video related materials, there may be some brief exposure of the patient's face.

The audio/video health information will be used by employees of CASCADE and potentially will be disclosed to the following individuals:

- Recipients of CASCADE advertising;
- Attendees of CASCADE workshops;
- Visitors to CASCADE's social marketing sites.
- Attendees of conferences at which CASCADE exhibits;
- Visitors to the CASCADE website;

I understand that this authorization will not expire, but that I may revoke it at any time by notifying CASCADE in writing. If I revoke this authorization, I understand that the revocation will not apply to CASCADE's uses or disclosures that occurred prior to CASCADE receiving the written revocation request.

I understand that once the above information is disclosed, it may no longer be protected by state and federal privacy laws and it may be re-disclosed by the recipient of the information.

I understand that this authorization is completely voluntary and CASCADE will not withhold any treatment, goods, or services if I choose not to sign this form.

☐ I authorize use of my first name and last name initial for these purposes.
- or -
☐ I prefer the use of a pseudo name in place of my real name.

Signatures:

Patient/Legal Representative _____ Date _____

If this form is signed by a Legal Representative, please indicate the relationship to the patient.

☐ Parent of a minor ☐ Court-appointed guardian ☐ Other

This Authorization shall be signed in duplicate with each party retaining an original.