



Social Media Release Form

This Social Media Release ("Release") is executed on _____ [DATE],
by _____ [RELEASOR'S NAME] ("Releasor"), who acknowledges and
agrees to the terms below:

- I hereby authorize Healthier Body Institute, its employees, agents, and representatives (hereinafter the "Releasee") the right to photograph, video record, and/or use my personal story and experiences related to my bariatric journey/treatment.
- I consent to the use of my likeness, before/after photos, videos, and/or testimonials for the following purposes on Releasee's website and social media accounts, including, but not limited to, Facebook, Instagram, TikTok, and X (Twitter), without acknowledgment or recognition given to the Releasor.
 - Educational purposes (medical teaching/training)
 - Marketing and advertising purposes (including but not limited to website, print ads, brochures, and internal office displays)
- I understand that identifying information such as my full name will not be used unless I specifically consent to its use here:
 - YES, ONLY my first name only may be used.
 - YES, my full name may be used.
- I grant the Releasee creative permission to alter the photographs, provided that the photographs are not altered in an explicit manner or used to maliciously represent the Releasor or their associates.
- I understand that I will not receive any monetary compensation from the Releasee for the permissions granted herein and hereby waive any right of inspection or approval of the photos or recordings prior to the Releasee posting on their social media accounts.
- I acknowledge that any third party (including any agency, client, publication, or other organization or institution) may distribute the photographs and recordings on their social media accounts for the purposes of publicity and promotion of the Releasee.
- I understand that by permitting the use and sharing of my protected health information (PHI) via public platforms like social media, this information is no longer protected by federal and state privacy laws (HIPAA) and can be re-disclosed by the general public.
- I acknowledge my participation is strictly voluntary. My decision to sign or not sign this form will not affect my treatment, payment, or eligibility for benefits.
- I understand that I may revoke this authorization at any time by providing written notice via email to Dr. Henry Lin at **drhenrylin@healthierbodyinstitute.com**. I am aware that revocation will only prevent future use of my information and is not retroactive for materials already published.

20 Roche Brothers Way,
Unit 6-322
North Easton, MA 02301



Henry Lin, MD FACS
(774) 227-8482, ext 802
admin@healthierbodyinstitute.com

I release Healthier Body Institute from any claims and demands arising out of or in connection with the use of the photographs/story, including claims for libel or invasion of privacy.

In witness whereof, the Releasor executes this Release by signing below.

Releasor's Signature: _____ Date: _____

Print Name: _____

If patient is a minor or incapacitated (Legal Guardian/Representative) sign on next page:

Signature: _____ Relationship to Patient: _____

Printed Name: _____