Synergy Release Sports LLC
Michael C. Zoeller LLC, Dr. Andrew Potter LLC, Dr. Mac Smith LLC, Dr. Dustin E. Albanese LLC, and Metro Wellness LLC

AUTHORIZATION FOR RELEASE OF INFORMATION
For Media, Public Relations, and Marketing Purposes

I, _____, authorize the above companies to take photographs, films, audio, video, or interviews of me for the purpose of marketing, research/education, or documentation.

1. I consent to the taking of photographs, films, audio, video, and interviews for use on our website and social media networks.

2. I understand that I may be identified in any use of the above materials.

3. I understand that Protected Health information including my name, diagnosis, and treatment/services may be identified in the above materials

4. I understand that I will not be compensated in any way for the taking and using of photographs, films, audio, video and interviews, or the publishing of said content.

5. I understand that at the time my health information is used or disclosed, it is no longer protected under state or federal law.

6. I understand that this authorization covers all periods of past, present, and future healthcare treatment to our facility.

7. I understand that I can cancel this Authorization at any time by mailing, faxing, or personally delivering a written letter to our address 6495 Shiloh Road suite 110, Alpharetta, Ga 30005.

8. I understand that the terms of my treatment or payment will not be conditional upon signing this authorization.

9. I understand and acknowledge that my child/children are under 18 years of age, and lack the legal capacity to enter into binding agreements. As such, I have read this release, and consent to my child's/children's inclusion in the materials listed above.

10. I agree that I have received a signed copy of this Authorization.

_____	_____	_____
Signature of Patient, Parent, or Guardian	If Minor, name of child	Date
_____		_____
Signature of Witness		Date