HIPPA Release Form/ Media release consent form

www.dreamdollzservices.com

First Name

Last Name

Primary Phone Number

Email Address

Acceptance and Agreement

I, hereby authorize Dream Dollz Services, its duly authorized employees to publish the following personal health information/story:

(e.g.,information referring to the diagnosis, treatment, surgeon, procedure, and health care service provided or to be provided to me and which identifies my name and other personally identifiable information).

I authorize the information above to be used in print, media, our website and associated blog and on the following social media platforms: Facebook, Instagram, TikTok and YouTube.

I understand I have the right to revoke this authorization by providing written notice to Dream Dollz Services. However, this authorization may not be revoked if Dream Dollz Services, its employees, have taken action on this authorization prior to receiving my written notice. I also understood that I have the right to have a copy of this authorization. I further understand that the authorization is voluntary and I may refuse to sign this authorization. My refusal to sign will not affect my services.

By signing below, I am acknowledging that I have read, understand and will comply with the above mentioned

Signature

Date