RIVER OAKS OB/GYN ASSOCIATES P.C.

2405 West Lexington Avenue, Elkhart, IN 46514 • (574) 295-8805

River Oaks OB/GYN Photo Submissions

Is your child's cuteness just too much to keep to yourself? We'd love to help! We're looking to spotlight (in accordance with HIPAA guidelines, of course) the amazing and adorable children we helped deliver on our social media channels.

What Won't Happen:

There will be no personal information shared with the photos. That means, NO names, NO birthdays, no mention of family members, NO addresses, NO information that could point back to you in anyway. Promise.

What Will Happen:

Your child's image will be featured in a monthly social media segment, along with other children as the "River Oaks Babies of the Month!" We ask that you not tag your child directly on our page, but if you feel like sharing the photo on your own pages, great!

What We're Looking For:

Photos of River Oaks delivered children. We think your baby is as beautiful as you do, but please keep photo submissions to three photos per child. Also, we will not be able to post photos of your children completely nude, so be sure to dress up those cuties for their R.O Social media debut!

How to Participate:

Take a look through our photo release form, sign and return via Email or in person at River Oaks OB/GYN. Once you have signedyour release, you can send photos to riveroaksphotos@eyedart.com, photos will be reviewed, approved and posted at the end of the month in which they were sent.

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Patient Authorization of Use and Disclosure of Photos

I _____ give River Oaks OB/GYN Associates, my permission to use photographs on their website, and/or Facebook for promotional purpose. The information used could contain minimum necessary protected health information (PHI) which will not include information such as name, address, phone numbers, social security numbers, dates related to you as an individual, so on.

I understand this authorization is valid for 6 years, or until requested termination date of _____. The Practice will not receive payment or other remuneration from a third party for using or disclosing the PHI.
I understand that I do not have to sign this authorization in order to receive treatment from the Practice, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

Patient signature: _____ Date: _____

Parent/Guardian signature: _____ Date: _____