McLaren HEALTH CARE

Name: _____
Address: _____
_____
Telephone: _____
Date of Birth: _____
Email Address: _____
MRN if applicable: _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PHOTOGRAPHY, EDUCATION, MARKETING, FUNDRAISING OR PUBLIC RELATIONS PURPOSES

The purpose of this authorization is to give permission to McLaren and its agents and/or employees to use and disclose protected health information ("PHI") about you and your condition or treatment for use in educational activities, advertising, fundraising, publicity activities and marketing for or about McLaren or any of its facilities or programs.

Description of the project including a specific description of the PHI involved and the type of audience that may be involved: Patient's story and photos may be shared in print and electronic formats with both internal and external audiences, on the hospital's website, social media sites and through the hospital's media partnerships.

_____

_____

I consent to the use of my PHI as described above and understand that Protected Health Information may include information in my medical record about my condition or treatment and may also include: (i) the taking of photographs, videotapes, or motion pictures of me or any parts of my body as I permit, (ii) the use of my likeness and voice in electronic or communication transmissions including but not limited to film, videotape, Internet web sites, or other forms of recording, or (iii) the use and disclosure of my name or any other information that may identify me. I have a right to inspect the information prior to its use or disclosure.

McLaren may use and disclose my Protected Health Information in print and televised media, including newspapers, magazines, television, radio, Internet, or to public relations and marketing firms.

List any limitations to the use of my information here:

_____

I understand and agree that this authorization is valid for fifteen (15) years unless I revoke or cancel it in writing as described below.

I realize that I will not be compensated in any way and hereby waive and forego any right, entitlement or claim that I might otherwise have to any compensation, fees or benefits by reason of any appearance on, or publication in, any communication media, including rebroadcasts or re-printings in accordance with the above. I specifically release McLaren and its agents, employees, or any person, firm or organization that McLaren may designate or authorize, from any liability or other obligation arising out of the use of such PHI as I have herein authorized or from the use of any materials furnished by me.

I understand that any disclosure of information carries with it the potential for re-disclosure and that once disclosed, the information may not be protected by state or federal law. For example, once an image is posted on an internet website, the image may be downloaded or printed by the public.

McLaren cannot make you sign this Authorization as a condition of receiving treatment, making payments, or gaining enrollment/eligibility in any health insurance plan.

I understand that I have a right to revoke this Authorization at any time by notifying McLaren, in writing, at the address listed below. If I choose to revoke this Authorization, I understand that my revocation will not affect any information already released by McLaren before receiving my revocation. My revocation should be sent to:

McLAREN HEALTH CARE PRIVACY OFFICER
One McLaren Parkway, Grand Blanc, MI 48439; or
Privacy@McLaren.org

Signature of Patient/Legal Representative: _____ Date: _____

Print Name of Patient/Legal Representative (if applicable): _____

Relationship of Representative: _____