BON SECOURS MERCY HEALTH

AUTHORIZATION TO USE AND DISCLOSE PERSONAL AND PROTECTED HEALTH INFORMATION FOR MARKETING, EDUCATIONAL AND/OR TRAINING PURPOSES

I, ____, authorize Bon Secours Mercy Health Inc., its affiliates, subsidiaries, employees and agents ("BSMH") to use and disclose my following information (check and complete each that applies):

- ☐ My name
- ☐ My photograph(s) and/or likeness, taken on __/__/20_at ____(location).
- ☐ My written, video, and/or audio interview and/or testimonial, recorded on __/__/20__, at ________________________(location).
- ☐ My protected health information from my care on _/_/20_through _/_/20_ at ________________________________(location),

  specifically: ____(attach separate page if needed);

  but excluding: ____(attach separate page if needed).

To and for any of the following (check each that applies):

- ☐ To the news media and BSMH for any marketing, public relations, internal communications and/or advertising purposes (e.g., print, TV, radio, Internet, blogs and social media).
- ☐ To BSMH for its education, training, presentation and/or publication purposes.
- ☐ To educational institutions and professional associations for any education, training, presentation and/or publication purposes.
- ☐ To: ____Purpose: ____

I understand that this Information may be used to produce video and/or audio recordings, photographs, electronic and/or printed materials for any authorized purpose, above. I agree that BSMH may use my Information for any authorized purpose without any compensation to me, and I will make no claim against BSMH for such compensation. I understand BSMH is not receiving any direct or indirect compensation for my Information as a part of this authorized disclosure. I understand and agree that BSMH may use and disclose my Information in connection with the distribution of information concerning unions or other organizations, including information relating to the issues raised in campaigns.

Unless excluded in writing, above, I understand that my protected health information may contain information regarding physical and mental illness (but not psychotherapy notes), HIV test results or diagnoses, treatment of AIDS or AIDS-related conditions, and alcohol or drug abuse. I understand that I may inspect or copy any protected health information to be used or disclosed under this authorization before such use or disclosure. I also understand that any Information that I authorize BSMH to disclose may be subject to re-disclosure by the recipient (e.g., news media) and no longer be protected by the Health Insurance Portability and Accountability Act ("HIPAA") or other applicable law. I understand that BSMH has no obligation to me concerning that recipient's use or disclosure.

Per BSMH's Notice of Privacy Practices, I understand that I may revoke this authorization at any time by sending a written revocation to the above address, and that the revocation is effective when BSMH receives it. However, that revocation does not apply to any Information previously used or disclosed in reliance upon this authorization. Unless revoked earlier in writing, this authorization expires on ____/____/20_____or, if I have left that date blank, then one (1) year from the date of my signature, below.

I understand that my signature is voluntary and that I can refuse to sign this authorization. I am not required to sign this authorization to obtain treatment, and BSMH shall not condition treatment on the signing of this authorization. By signing this authorization, I release BSMH from all liability related to its authorized use and/or disclosure of my Information. I agree that I have had a reasonable opportunity to ask questions about this authorization and that all such questions have been answered to my satisfaction.

Signature:____**Date**: ____________

Personal Representative (if applicable): ____**Date**: ____________

- ➢ Description of Authority (attach supporting documentation if necessary): ________________________________

Bon Secours Mercy Health Representative: _________________________________**Date**: ____________

Translator (if applicable): ____**Date**: ____________