AUTHORIZATION TO USE OR DISCLOSE CERTAIN INFORMATION FOR MARKETING, PUBLIC RELATIONS, AND EXTERNAL COMMUNICATIONS

SECTION I:

I authorize **Conemaugh Health System's Donor Advisory Committee** and any of its affiliates and their representatives to use
(Provider)
or disclose the name and photographic or video images of _____ DOB: _____
(Name)
for promotional, educational and informational purposes (i) in any printed publication, advertisement, or website of Provider and its affiliates; (ii) to local, state, and national government officials; reporters for local, state, and national media publications, including newspapers, magazines, and on-line media; and to reporters for local, state, and national television broadcast stations; and or (iii) as otherwise specifically described:

Inclusion in Donor Recognition Wall interactive kiosk at Conemaugh Memorial Medical Center

I acknowledge that my participation pursuant to this Authorization is voluntary and that I will receive no financial compensation for the use of my name or images as provided by this Authorization. I further agree that the use of my name or images as provided by this Authorization confers upon me no rights of ownership whatsoever. I agree that Provider and its affiliates may use images of me with or without my name and for any lawful purpose, including but not limited to publicity, education, illustration, advertising, or web content. I release Provider and its affiliates from liability for any claims by me or any third party in connection with my participation pursuant to this Authorization.

I am: □ a patient of Provider **(Complete Section II and Section III)**.

I am: ☒ **not** currently a patient of Provider **(Skip Section II and Complete Section III)**.

SECTION II:

Date(s) of Relevant Service or Encounter:	N/A

PROVIDER USE ONLY:

□ **Provider may receive payment from third parties for marketing activities allowed pursuant to this Authorization.**

□ **Provider does not receive payments from third parties for marketing activities allowed pursuant to this Authorization.**

The type and amount of information to be used or disclosed regarding the above-referenced date(s):

☒ Patient's name and/or image
□ Name and specialty of physician(s)
□ Medical Record (specify portion for use or disclosure): _____
☒ Other (Describe): **Information submitted on living donor or recipient participation form**
□ Diagnosis and/or type(s) of treatment received
□ Description of treatment experience

The format in which such information may be used or disclosed:

☒ Interview and/or use of quote from patient or physician
☒ Photographic or video images

I hereby authorize the use or disclosure of information about the above named individual and I understand that:

1. I may refuse to sign the Authorization.
2. This Authorization includes information relating to behavioral or mental health services, alcohol and drug treatment, sexually transmitted disease, acquired immunodeficiency syndrome, or human immunodeficiency virus, if any.
3. I have the right to revoke this Authorization at any time in writing.
4. Any revocation will be effective only to the extent that action has not been taken in reliance on my prior authorization. Unless I revoke this Authorization, it will expire five (5) years after the date I sign this Authorization or, if shorter, the maximum period allowed by state law.
5. By signing below, I recognize that the health information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of this disclosure.
6. Treatment or payment will not be conditioned on my signing this Authorization.
7. I have received a copy of this Authorization.

SECTION III:

I have read the above and authorize the use or disclosure of information about me as stated herein.

_____ _____
Signature of Individual or Individual's Personal Representative Date

_____
Relationship of Personal Representative to Individual