SOUTH COUNTY HEALTH

AUTHORIZATION AND RELEASE TO DISCLOSE
PROTECTED HEALTH INFORMATION IN MEDIA OR COMMUNICATIONS

Name: _____ Date of Birth: _____

Address: _____

Phone number: _____Email:_____

I authorize South County Health (SCH) to use the following information in media or marketing communications efforts:

- My full name
- My image (photograph, video, film, etc.)
- My story and statements
- Medical information specific to my story (diagnosis, procedures, treatment information, etc.)
- Medical billing information (charity care, if applicable)

I understand the following:

- I can refuse to sign this Authorization and Release.
- I can revoke this Authorization and Release at any time for any reason by sending a written revocation to South County Health's Communication team sent by regular mail or a delivery service such as Federal Express or UPS to 100 Kenyon Ave., Wakefield, RI 02879, or by electronic mail. The email address is marketing@southcountyhealth.org. The revocation shall be effective upon receipt. If I do that, my information cannot be further disclosed after I revoke. Absent revocation, this Authorization will be of indefinite duration.
- Refusing or changing my mind about this Authorization and Release will not negatively affect my or my family's healthcare treatment, payment for healthcare, or eligibility for benefits.
- Federal and state laws and privacy rules govern South County Health's use of this information. I intend this Authorization and Release to be effective under all such laws and rules. I may ask for a copy of SCH's use of Joint Notice of Privacy Practices or find it on SCH's website.

By signing below, I authorize South County Health to share my story in electronic, audio, print and news media. Examples include paid advertising, patient brochures, fundraising efforts, website, and social media. I acknowledge and understand that the information shared by South County Health may be re-shared by media sources and other private parties through digital and social media.

I release and hold harmless SCH, its employees, agents and affiliates in perpetuity from any and all claims, obligations, damages, compensation and/or liability arising from this disclosure and use of my information.

I acknowledge that before executing this Authorization, I have had the opportunity to ask South County Health questions about this Authorization and that I either have no such questions or have received answers to the questions that I have.

Patient or Legal Representative Signature:_____

Print Name: _____

Date: _____

Relationship to Patient, if applicable:_____