Van Buren County Hospital
Simply Remarkable

An Affiliate of MERCYONE

Authorization for Use/Release of Information/Photography

____
Patient Name, *please print*

____________________ (____) _____ – _________
Birthdate Phone Number

1. Person(s) authorized to use/disclose. I permit any authorized representative or agent of Van Buren County Hospital to share my identity and protected health information, including related interviews, images, quotes, comments and videos internally, for educational or business purposes, or externally, for advertising, marketing, social media, public relations, public affairs or similar activities. Specific projects include:

   Describe expected project(s) here, for instance, "Baby Friendly Nursery Campaign," "April News Conference," CEO interview/presentation, etc.

   ____

2. I understand that other individuals, organizations or businesses may receive my information either directly or indirectly and that they may share it with their own audiences. I further understand that Van Buren County Hospital has no control over such reuse of my information. Recipients may include:
   - Public audiences
   - Journalists, media outlets and/or their representatives
   - Other health care and/or government organizations
   - Local, state and/or federal policymakers
   - Researchers or educators

3. If there is any information you prefer us not to share, please describe it here:

   ____

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4. Compensation. I understand that I will not be compensated in any way for participating in this agreement or for the use of my image, quotes, comments or information.

5. I authorize the storage, reuse and re-disclosure of the information described above -- and for the purposes described above — for one year from the date signed. I understand that I can cancel this authorization in writing, or in person, any time and that the cancellation will prevent all future disclosures by Van Buren County Hospital. I can cancel my authorization at any time by calling the department holding the signed documents and verifying my identity, but I understand this request is only legally binding if I cancel my authorization by mailing, faxing or taking a letter and proof of my identity in person to Van Buren County Hospital that initiated this authorization. I also understand that a representative of Van Buren County Hospital will contact me to authorize any other or further uses of my information.

6. Statement of Understanding. I understand that Van Buren County Hospital cannot require me to sign this authorization as a condition of getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan.

______________________________ ____________________ __________

Signature of Patient or Patient Representative | Relationship to Patient | Date

TO BE FILLED OUT BY Van Buren County Hospital COLLEAGUE

______________________________ ____________________ __________

Witness Name and Title *please print* | Witness Signature | Date

____________________ And/Or ______________________________________

Patient MRN/ID Number | Patient Street Address | City/State/Zip