MUNSON HEALTHCARE

FORM #2397 (04/17)

AUTHORIZATION TO CONTACT, INTERVIEW, PHOTOGRAPH, RECORD, OR RELEASE PROTECTED HEALTH INFORMATION FOR PROMOTIONAL/EDUCATIONAL PURPOSES

Information about you and your health is personal, and Munson Healthcare is committed to protecting the privacy of that information. When we want to share your information for the public to see or hear, we must ask you for written permission (authorization). You can ask to stop an interview or recording session at any time.

Please read this form carefully and ask any questions you have before signing it.

I, (PRINT NAME) _____ **authorize Munson Healthcare and/or its affiliates and service organizations to contact, interview, take audio/photography/video of me, and to use and/or share information about me for promotional and/or educational purposes on behalf of Munson Healthcare, including:**

- Advertisements, brochures, electronic communications, multimedia productions, publications, social media, web sites, etc., directed to staff, physicians, volunteers, patients, visitors, and the general public
- Local or national news media coverage

Information about me to be used and/or shared includes:

- ☐ My appearance/likeness on recorded or electronic media *(e.g. interview notes, audio, photographs, video, etc.)* and information about my diagnosis and treatment gathered though interviews with me by Munson Healthcare staff or the news media
- ☐ Information, including Protected Health Information, gathered through interviews with health care providers and others involved in my care *(e.g. physicians, nurses, technicians, staff, etc.)*

I understand that signing or refusing to sign this authorization will not affect the delivery of care in any way.

I understand that this authorization does not include any promise to pay me and that Munson Healthcare will not receive payment of any kind for the use of information/material covered by this authorization.

I understand that information/material covered by this authorization may be used at any time, with no expiration date.

After signing this authorization, I understand I may change my mind and revoke this authorization in writing, except to the extent of action already taken based on this authorization. Once information/material is used and/or shared as allowed by this authorization, it is no longer protected under federal and state privacy laws and may be subject to re-disclosure.

I release and forever discharge Munson Healthcare and its agents, from any claims and demands in connection with the use of information/material covered by this authorization, including, but not limited to, any claims for invasion of privacy or defamation.

SIGNATURE (INDIVIDUAL OR RESPONSIBLE REPRESENTATIVE): _____

NAME OF RESPONSIBLE REPRESENTATIVE (if applicable): _____ RELATIONSHIP TO INDIVIDUAL: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ EMAIL: _____

SIGNATURE (WITNESS/ORG. REPRESENTATIVE): _____

NAME (WITNESS/ORG. REPRESENTATIVE): _____ DATE: _____ TIME: _____

INTERNAL USE:

TOPIC: _____

_____

_____

ORGANIZATION:

- ☐ Kalkaska Memorial Health Center
- ☐ Mackinac Straits Health System
- ☐ Munson Healthcare Cadillac Hospital
- ☐ Munson Healthcare Charlevoix Hospital
- ☐ Munson Healthcare Grayling Hospital
- ☐ Munson Healthcare Home Health
- ☐ Munson Healthcare Manistee Hospital
- ☐ Paul Oliver Memorial Hospital
- ☐ Munson Medical Center
- ☐ North Flight EMS
- ☐ Otsego Memorial Hospital
- ☐ Other MHC Affiliate (Please Specify) _____