OLMSTED MEDICAL CENTER

Authorization for Use and Disclosure of Patient Health Information

(Patient Publicity)

Patient Label or

Name: _____

Patient/Chart ID: _____

DOB: _____

Section I:

I, _____, authorize
(Patient Name)
Olmsted Medical Center to use and disclose the following information: (select one of the following)

☐ My image(s) (e.g., my picture in still photos, my image on a videotape) **OR** ☐ My image(s) and name

together with the fact that I am/have been an Olmsted Medical Center patient and have received treatment for or related to: _____.

Section 2:

Olmsted Medical Center will use and disclosure the information above for the following purposes:
(select all that apply)

- ☐ Olmsted Medical Center's marketing purposes, or OMC Regional Foundation's marketing purposes. [For example, for printed brochures or for use on Olmsted Medical Center's website(s) and/or social media]
  - ☐ Tag on Instagram
  - ☐ Tag on Facebook
- ☐ Patient education and information. (For example, to show other patients how a procedure works, or the results of a particular treatment.)
- ☐ Healthcare provider education and information. (For example, for use at medical education seminars.)
- ☐ Other (describe): _____

Section 3:

The information described above may be disclosed to the following recipient(s):
(select all that apply)

- ☐ Olmsted Medical Center patients or potential patients who are considering treatment related to the treatment described above.
- ☐ Visitors to the Olmsted Medical Center website(s).
- ☐ Visitors to Olmsted Medical Center who will see my image as part of an on-site display.
- ☐ Attendees at medical conferences, medical educational lectures, and similar events where Olmsted Medical Center staff will present the information.
- ☐ Readers or viewers of medical publications.
- ☐ Other (describe): _____

I understand that Olmsted Medical Center will not condition my treatment on whether I sign this authorization.

I understand this Authorization for Use and Disclosure of Patient Health Information is valid from the date signed unless revoked by me.

I understand that I may revoke this authorization by sending a written request for revocation to Olmsted Medical Center's Privacy Officer. If I revoke this authorization, Olmsted Medical Center will no longer use or disclose my medical information as described in this authorization, except to the extent it has already relied upon this authorization. I understand that when Olmsted Medical Center discloses information pursuant to this authorization, the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information.

I understand and agree to the terms of this authorization:

Name of Patient (Printed)	Patient/Parent/Legal Guardian Signature	Date/Time

Name of Interpreter (Printed) (if used)	Interpreter Signature	Date/Time