Authorization to Use or Disclose Health Information

(Promotional Material)

Patient Name: _____ DOB: _____ MRN #: _____

In accordance with the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996. *I understand that I am under no obligation to sign this form and that Elara Caring, who I am authorizing to use and/or disclose my health information, may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.*

1) **I authorize the following health information to be used and/or disclosed:** *My name, title, portrait, picture, video image, photograph or any reproduction or likeness of me or quotation of my remarks which includes any service promotions or fundraising purposes.*

2) **I authorize my health information to be used and disclosed for the following purposes:** *For public informational, promotional materials and/or online/social media use regarding Elara Caring.*

3) **I authorize my health information to be used and disclosed to:** *Any recipient of the public informational and/or promotional materials regarding Elara Caring.*

4) **My right to revoke this authorization.** *I understand that I have the right to revoke this authorization at any time. I also understand that my revocation of this authorization must be in writing. To obtain a copy of an authorization revocation form I may contact the* ***Privacy Officer at Elara Caring, 14295 Midway Rd, Addison, TX 75001; 800-646-8773.*** *I am aware that my revocation will not be effective if (i) this authorization was obtained as a condition for obtaining insurance and applicable law permits the insurer to contest the claim or the policy itself or (ii) to the extent the person(s) and/or organization(s) identified above have already acted in reliance upon this authorization.*

5) **Redisclosure.** *I understand that once my health information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may no longer be protected by federal privacy laws or regulations*.

6) **Disclosure of direct or indirect remuneration received by any person and/or organization authorized to use and/or disclose my health information.** *I understand that no one will be receiving direct or indirect remuneration in connection with the use and / or disclosure of my health information as described in 1) except that I understand it may be used in the solicitation of donations for fundraising purposes to support the Hospice Foundation.*

7) **Expiration of authorization.** *This authorization will be in effect until Elara Caring no longer operates a hospice or until the following date or event:* ☐ No Expiration Date **or** ☐ Other Date: _____/_____/_____

_____ _____/_____/_____

Patient Signature Date

If Patient is unable to sign, complete the following:

Patient is unable to sign because: _____

Name of Personal Representative: _____

Relationship to Patient: _____

Authority of Personal Representative (e.g., health care power of attorney, guardian, other statutory authorization):

_____

Address: _____

Home Ph #: _____ Work Ph #: _____ Email: _____

_____ _____/_____/_____

Signature of Personal Representative Date