Hospital Sisters HEALTH SYSTEM

Authorization to Photograph/ Video Record/Interview and/or Use and Disclose Protected Health Information for Marketing/Communications

Name of "Subject": _____

Address: _____

Phone/Email: _____

Marketing Material: Marketing Material may include video images, photographic images, conversations, sounds, audiotapes, verbal and/or written testimonials, statements, biographical information and/or protected health information (including but not limited to name and disease state). Other (list additional marketing material): _____

Purpose: Use and disclosure for marketing and promotional purposes, including but not limited to, publication in newspapers, magazines, patient information material, television, intranet, internet advertisements, educational or social media platforms, and other public mediums or in any other advertisement on behalf of the Organization and its affiliates, including but not limited to, the Organization's charitable Foundation. Other: _____

Authorization: I hereby authorize the "Organization" checked below to acquire "Marketing Material" pertaining to Subject and allow use and disclosure for the Purpose as stated above (check the box of all organizations that apply):

Wisconsin:

- ☐ St. Vincent Hospital
- ☐ St. Nicholas Hospital
- ☐ Libertas Treatment Ctr
- ☐ St. Mary's Hospital Medical Ctr
- ☐ St. Clare Memorial Hospital
- ☐ Prevea Health

Illinois:

- ☐ St. John's Hospital
- ☐ St. Elizabeth Hospital
- ☐ St. Francis Hospital
- ☐ Good Shepherd Hospital
- ☐ Holy Family Hospital
- ☐ Prairie Cardiovascular Consultants
- ☐ St. Mary's Hospital
- ☐ St. Anthony's Memorial Hospital
- ☐ St. Joseph's Hospital - Breese
- ☐ St. Joseph's Hospital - Highland
- ☐ Medical Group

Limitations: Marketing Material shall not include the following (identify limitations, if any): _____

I, Subject, understand that:

1. This authorization is strictly voluntary.
2. This authorization doesn't expire, and I may revoke it at any time in writing. A revocation will not have any effect on any actions taken by Organization or recipient in reliance upon the authorization prior to receiving my revocation. A description of how to revoke the authorization is located in the Organization's Notice of Privacy Practice.
3. The Marketing Material may be subject to further disclosure by recipients and no longer protected by law.
4. Whether I sign this authorization or not, my health care, payment, enrollment or eligibility for benefits will not be affected.
5. I may obtain a copy of the Marketing Material if I ask for it. **By signing this authorization, I am waiving my right to inspect or approve the publication or dissemination of the Marketing Material or to receive any compensation regarding the use of the Marketing Material by the Organization for the Purpose.**
6. This authorization shall act to release the Organization and its agents and employees from any liability connected with the Marketing Material for the Purpose to the maximum extent permitted by law.
7. A photocopy of this authorization shall have the same force and effect as the original.

Signature of Subject: _____

If Subject is unable to sign, complete the following: (check all that apply)

- ☐ Individual is a minor, legally incompetent or incapacitated
- ☐ Signatory has legal authority to sign (i.e., a parent*, legal guardian, or activated POA for Health Care)

Name of legal authority: _____
Address: _____
Phone/Email: _____

Signature of legal authority: _____

*By signing above, I hereby declare that I have not been denied physical placement of this child.