PROMEDICA SENIOR CARE
AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION FOR MARKETING PURPOSES

I, _____ authorize ProMedica Senior Care to use and disclose my health records and demographic information, including photographic and video images, for marketing purposes, including the creation of promotional, educational and informational materials to be distributed by ProMedica Senior Care

Legal Authority for Request (please initial)

_____ I am the patient/resident noted above.

_____ I am the patient/resident's responsible party and am authorized under state law to act on behalf of the patient/resident.

Understandings & Agreements of Requestor

1. I understand that this authorization is voluntary and that my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this use and/or disclosure.
2. This authorization will expire when ProMedica Senior Care is no longer using the information requested in the promotional, educational or informational materials being distributed by ProMedica Senior Care for marketing purposes.
3. I understand that I may revoke this authorization at any time by notifying Senior Care in writing at the address below, but if I do, it will not have any effect on any actions taken prior to my revocation.

ProMedica Senior Care
Marketing Communications
333 N. Summit St.
Toledo, OH 43604

4. I understand that once the information described is disclosed, it may be subject to redisclosure and it may no longer be subject to the privacy protections afforded by ProMedica Senior Care if the recipient of the information is not a health plan, health care provider, health care clearinghouse, or a business associate that has a contract with the ProMedica Senior Care.
5. I understand that I have the right to receive a copy of this Authorization

_____ _____
Signature of Patient or Responsible Party Date

_____
Printed Name of Patient or Responsible Party

Employees & Visitors Only:

PROMEDICA SENIOR CARE
Authorization for the Release of Photographic Images, Video and Testimonial Copy

I, _____ hereby authorize ProMedica Senior Care. to use and disclose the following individually identifiable information.

___ Testimonial Copy
___ Photographs
___ Video
___ Other: _____

Understandings & Agreements of Requestor

1. I understand that this authorization is voluntary. I further understand that no special compensation will be provided to me for use of my image and that I may not be informed in advance of the specific use of my image.
2. This authorization will expire when the information requested is no longer being used by ProMedica Senior Care in the promotional, educational or informational materials being distributed by ProMedica Senior Care for marketing purposes.
3. I understand that I may revoke this authorization at any time by notifying ProMedica Senior Care in writing at the address below, but if I do, it will not have any effect on any actions taken prior to my revocation.
4. I understand that I have the right to receive a copy of this Authorization.

ProMedica Senior Care
Marketing Communications
333 N. Summit St.
Toledo, OH 43604

_____ _____
Signature of Employee: Date

_____
Printed Name of Employee