



THE RICHLAND HOSPITAL, INC. AND THE RICHLAND HOSPITAL FOUNDATION AUTHORIZATION AND CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION FOR MARKETING PURPOSES

This authorization form allows The Richland Hospital, Inc. and The Richland Hospital Foundation (collectively "Richland") to use protected health information (including but not limited to photographs and video recordings containing identifiable images that contain such information) for the purposes of marketing and advertising. For example, this authorization would allow Richland to publish photographs or videos containing protected health information ("PHI") on its website or on social media.

1. **Patient Name:** _____.
2. **Information To Be Released:** I authorize the release of any and all protected health information, with the exception of the following information or limited to the following dates of service: _____.
(If blank, I am not limiting the scope of the PHI to be released).
3. **Purpose.** By signing below, I authorize use or disclosures of PHI for myself or as legal representative of the above-named patient, for the purposes of advertising, marketing or public relations by Richland.
4. **No Requirement To Sign This Authorization.** This authorization is made voluntarily. I acknowledge and agree that I am under no obligation to make this authorization and that the Richland has not conditioned any treatment, payment, enrollment, or eligibility for benefits on my signing this Authorization.
5. **Redisclosure.** I understand that redisclosure may not be protected by the applicable privacy laws.
6. **Duration and Right To Revoke.** This authorization will be effective as of the date of my signature below and will remain effective unless or until I revoke it. I understand that I may revoke this authorization at any time, except to the extent that the Richland has published or disclosed PHI in reliance on this authorization. To revoke my authorization, I understand that I must send a written or emailed request for revocation to Marketing@richlandhospital.com or The Richland Hospital and Clinics Marketing Department, 333 East Second Street Richland Center, WI 53581. I understand that my revocation is effective only if it is in writing or email.
7. **General Acknowledgements.** I understand, acknowledge, and/or agree that:
 - I understand that I will not receive any payment or other consideration in exchange for signing this document or for authorizing the use or disclosure of PHI.
 - I understand that if I sign this authorization, I have the right to receive a signed copy of this authorization.
 - I understand that I have the right to inspect and copy PHI that is used or disclosed pursuant to this Authorization, with certain limitations, and that if I wish to receive a copy there may be a fee.
 - I understand that I will not be receiving any direct or indirect payment for signing this Authorization.

I understand that my signature below means that I have read and understood this document.

Signature of Patient or Legal Representative

Date