Authorization for Use of Your Health Information for Media, Marketing and Communications Purposes

Purpose of this Form

The Independence Center (The IC) is pleased to share personal stories while also protecting privacy by following federal and state privacy laws. The federal Health Insurance Portability and Accountability Act (HIPAA) gives you protections concerning the use and release of your personal health information, in addition to protections provided under Colorado laws. HIPAA requires that we give you this authorization form for your review and signature. By signing this form you are authorizing The IC to use and make public your name and health information for marketing, publicity, fundraising, media, and communications purposes on behalf of The IC.

Authorization to Use Health Information

This authorization permits The IC to use and disclose to the public the health conditions, personal identifying information and treatment or services that you discuss or share with The IC. This authorization also permits The IC to use and disclose to the public those health conditions, personal identifying information and treatment or services that you voluntarily discuss with individuals or entities preparing an article, broadcast story, video or marketing, fundraising, or promotional product on behalf of The IC.

- I understand that my name and information and details about my health or location that could disclose my identity may be revealed.
- By signing this authorization, I relinquish and waive any right to payment or compensation for such uses, and I and my successors and assigns also release and hold harmless The IC, its staff, employees, directors, representatives and its affiliated entities from any and all claims for injuries I may have now or in the future, of any nature whatsoever, which may result from the use of my name or my health-related information.

Signing this Form is Voluntary and You May Later Change Your Mind

Signing this form is entirely voluntary. If you do not sign or if you later revoke your authorization, it will not affect the continuation or the type of services you receive through The IC. If you change your mind after signing this form, you can revoke or withdraw this Authorization. To revoke this Authorization, you must send a written notice of your revocation to The Independence Center, Marketing and Communications Department, 729 S. Tejon St., Colorado Springs, CO 80903.

- I understand that a written notice revoking this Authorization will be effective upon receipt by The IC, except that the revocation will not have any effect on any action taken by The IC in reliance on this Authorization before it received my written notice.

How Long Will this Authorization Be in Effect

Unless I send written notice revoking my authorization as described above, this authorization form will remain in effect and will not expire until ten (10) years after the date I sign it.

Will My Health Information Be Used for Other Purposes

The IC will not use or disclose your name and health information for purposes other than those described and authorized in this form, unless we obtain your written authorization or as otherwise specifically required or permitted by law. However, you understand that you are authorizing disclosure of the health-related information and personal identifying information that you share with The IC or others acting on its behalf to prepare articles, stories, and printed materials which will be shared with the public. Once such information is made public, federal privacy laws and the protection they offer would generally not apply, and The IC would be unable to reverse, prevent re-disclosure by others, or make private what has already been shared in the public domain.

By signing below, I am indicating that I have read and understand this Authorization form, I have had an opportunity to ask questions, and I am signing knowingly and voluntarily for use and disclosure of my name and the health information that I share with The Independence Center or those acting on its behalf as described above.

Decline: ☐ Accept: ☐

_______________________________ _______________________
Signature of Consumer/Client/Volunteer (or Legal Guardian) Date

_______________________________ _______________________
Consumer's Full Name (Printed) Consumer's Telephone Number

_______________________________ _______________________
Address City, State Zip Code