Permission to Use Your Information or Image

Information about you and your health is personal, and Ortonville Area Health Services (OAHS) is committed to protecting the privacy of that information. When we want to share your information for the public to see or hear, we have to ask for your written permission (authorization). If you let us use your private information, you can ask how it will be used. You can also ask to stop the interview, recordings, films or photos at any time. People will likely know it is you in the promotion, so please read this form carefully and ask any questions you have before signing it.

I, _____, give written permission for OAHS Marketing and Communications and/or their representatives to use and/or share health information about me for:

- ☐ OAHS promotional purposes
- ☐ Learning/Educational purposes
- ☐ Local and national media
- ☐ Other: _____

Information about me to be used and/or shared includes:

- ☐ My appearance on photographs, films, audios or videos (or any other image)
- ☐ Information gathered through interviews with me or physicians and others involved in my care by OAHS staff or news reporters
- ☐ Other: _____

The information checked above becomes OAHS property or property of a news agency, and it may be used until OAHS or the media no longer want to use it. Once the information is shared, it is no longer protected under federal and state privacy laws and may be subject to re-disclosure. OAHS and/or their representatives will not receive payment of any kind for the use of your information.

Signing or refusing to sign this will not affect your care in any way. This permission does not include any promise to pay you. After you sign the permission form, you may change your mind unless the information has already been used or shared.

Please contact OAHS Marketing at 320-839-4138 if you change your mind and do not want to give us permission to use your information. This authorization will expire one year from the date of signature or _____, whichever is sooner.

Comments:_____

_____ _____
Name Date of Birth

_____ _____
Signature/Legal Representative Signature Date/Time

_____ _____
Name of Legal Representative (if applicable) Relationship

Ortonville Area Health Services

Name: _____

Address: _____

_____

Phone: _____