1500 Koenigstein Avenue
Norfolk, NE 68701
Phone (402) 371-4880

AUTHORIZATION FOR RELEASE OF INFORMATION

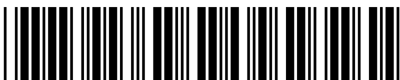
For Media/Public Relations, Fundraising and Marketing Purposes

I authorize Faith Regional Health Services the use and/or disclosure of my protected health information as described below:

1. I authorize Faith Regional Health Services to disclose to media representatives and/or public affairs staff members protected health information and information about me, my condition or treatment for purposes of publicity, promotion, education or publication in print, broadcast and electronic media. This authorization includes my likeness on photo, videotape and digital media. My authorization applies to the information described below. Only this protected health information may be used and/or disclosed pursuant to this authorization:
   - ☐ Print (newspaper, newsletter, brochure, etc.)
   - ☐ Faith Regional/Physician Services Web Site
   - ☐ Television (commercial, training video, etc.)
   - ☐ Social Media (Facebook, MySpace, Twitter, You Tube, etc.)
2. This authorization expires 10 years from the date I sign this authorization
3. I understand that once my protected health information is used and/or disclosed pursuant to this authorization, it may be subject to Redisclosure by the recipient(s)
4. I understand that I have the right to revoke this authorization at any time. My revocation must be in writing as described in the Notice of Privacy Practices. I am aware that might revocation is not effective to the extent that I have authorized the use and/or disclosure of my protected health information and such use and/or disclosure has been relied upon by authorized recipients.
5. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Faith Regional Health Services nor will it affect my eligibility for benefits.
6. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed in accordance with the Notice of Privacy Practices.
7. I agree that I will receive no financial remunerations for the use of my image or protected health information as described herein.

I certify I understand the authorization as described as above.

Signature of Patient or Legally Authorized Representative	Date
Relationship to Patient (If Legally Authorized Representative)	Witness



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