AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR MARKETING AND FUNDRAISING

I, _____, **[Print Name]** hereby authorize Echoing Hills Village, Inc. and all members of its organized health care arrangement ("Echoing Hills") to use and/or disclose my individually identifiable health information described below for marketing and fundraising purposes as follows:

Information to be used or Disclosed. Echoing Hills is authorized to use or disclose the following individually identifiable health information for purposes of marketing and fundraising activities:

(Please check all that apply)

☐ Name
☐ Full Face Photographic Images and any Comparable Images
☐ Week of Camp
☐ Address
☐ Other (describe):_____
☐ All of the Above

Authorized Recipient. Echoing Hills is authorized to use or disclose the approved individually identifiable health information for its own marketing and fundraising purposes and to disclose the same to the following classes of persons for marketing and fundraising purposes:

- ✓ Professional Fundraisers
- ✓ Print and Print Design Companies
- ✓ Public Relations
- ✓ Staff Recruiting
- ✓ Support Groups
- ✓ Charitable Organizations
- ✓ Website Developers

Your Refusal to Sign this Authorization:

Echoing Hills may not condition treatment or participation in its programs or activities on whether or not you sign this Authorization. If you refuse to sign this Authorization, Echoing Hills will not withhold treatment and will not restrict your participation in its programs and activities.

Re-disclosure: I understand that the information used and/or disclosed pursuant to this Authorization may be re-disclosed by the recipient of the information without my authorization and may no longer be protected by Federal law.

Expiration: This Authorization will expire on _____ _____ **[insert date or describe event].**

Revocation: I understand that I may revoke this Authorization at any time by notifying Echoing Hills in writing by sending a letter to Echoing Hills Village, Inc., 36272 C.R. 79, Warsaw, Ohio 43844, Attention: Privacy Officer or completing and returning a Revocation of Authorization. I understand that if I revoke this Authorization, it will not affect any actions Echoing Hills took before it received my revocation letter.

_____

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE **DATE**

Printed name of patient's representative, if applicable:_____

Relationship to patient:_____

REVOCATION OF AUTHORIZATION

Echoing Hills Village, Inc. ("Echoing Hills") respects a patient's right to privacy, information security and confidentiality in accordance with the privacy regulations contained within the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Social Security No./Health Record Number: _____
Date of Birth: _____
Address: _____
City/State/Zip Code: _____

I, _____ **[Print Name of Patient]** hereby revoke the **marketing** and fundraising authorizations, and I do not wish that my individually identifiable health information may be used or disclosed by Echoing Hills for any **future marketing or fundraising** purposes**.**

I understand that this authorization revocation does not apply retroactively, and will not affect any actions that Echoing Hills took before it received and processed this request.

_____
SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE DATE

Name of patient's representative (printed), if applicable: _____
Relationship to patient: _____