KAERBEARS HEALTHCARE LLC

AUTHORIZATION FOR USE OF INFORMATION AND/OR PHOTOGRAPHS AND WAIVER APPLICABILITY OF HIPAA AS IT RELATES TO THE INFORMATION AND/OR PHOTOGRAPHS PROVIDED FOR USE.

Patient Name: ____
(first) (m. initial) (last)

Address: ____
(street address)

____
(city) (state) (zip code)

Medical Record #: ____________ **Birth Date:** ____________ **Telephone # :** ____________

KAERBEARS HEALTHCARE is grateful to patients who are willing to share their stories. Information about the care you received, the staff you met and your experiences can prove enormously helpful to others interested in knowing more about health care today.

At the same time, the privacy of patients and families, as well as the confidentiality of medical and related information, are among our highest priorities. Therefore, permission always is sought from patients or their families or guardians to provide names, photos and information about home health care and treatment to the news media. A permission is also sought to use this information and visual material in official Kaerbears communications, such as publications, articles, brochures, Web sites, video and audio tapes. This authorizations also server as a waiver of applicability for HIPAA fas it relates to the the information and / or photographs provided for use. To make certain that we are using your personal information with your authorization, Kaerbears keeps on file a copy of your written permission. Would you, therefore, please take a minute to fill out and sign this form?

- I do ____, do not ____ give my permission for Kaerbear's Healthcare LLC to share information about my treatment and experiences Kaerbear's Healthcare LLC patient in publications produced by Kaerbears Healthcare. This permission extends both to electronic versions on the Kaerbear's Web sites and printed versions.
- I do ____, do not ____ give my permission for Kaerbear's Healthcare LLC to use my photographs or images in publications produced by Kaerbear's Healthcare LLC. This permission extends to both electronic versions on the Kaerbear's Healthcare LLC Web sites and printed versions.
- I do ____, do not ____ give my permission for Kaerbear's Healthcare LLC to use my information, photographs and images in electronic media (DVDs, CDs, digital files podcasts, vodcasts, WMF and similar) produced by Kaerbear's Healthcare LLC on Kaerbear's Healthcare LLC web sites and on Kaerbear's Healthcare LLC portals or channels on external sites such as Facebook, You Tube and similar sites).
- I do ____, do not ____ give permission for Kaerbear's Healthcare LLC to provide my name and contact information to the public news media including, but not limited to, TV, radio and newspapers in connection with my treatment and experience as a Kaerbear's Healthcare LLC patient.
- I do ____, do not ____ give permission for Kaerbear's Healthcare LLC to disclose my photographs or other images, or information about my treatment and experiences as a Kaerbear's Healthcare LLC patient, to the public news media including, but not limited to, TV, radio and newspapers, and to other commercial media photographers and videographers.
- I do ____, do not ____ give permission for Kaerbear's Healthcare LLC to allow TV, radio, newspapers and other commercial media photographers and videographers to make images of me/my child(ren)/my family member for purposes of illustrating my treatment and experience as a Kaerbear's Healthcare LLC patient.

If any of the permissions above are given, I hereby release and waive all claims to compensation and rights regarding such use and/or publication.

I understand that:

- This authorization is voluntary. My treatment will not be impacted, no matter if I sign this authorization or not.
- If I do not sign this authorization, Kaerbear's Healthcare LLC will not disclose my health information as requested.
- I will receive a copy of this authorization upon signature.
- This authorization will end only when the use and disclosure of my information is no longer needed for the purposes agreed to above. I may revoke this authorization by mailing or faxing my written request along with a copy of the original authorization to the clinic or department where my authorization was made or given or to Kaerbear's Healthcare LLC Medicine's department of Marketing and Communications.
- This withdrawal would affect only future use and disclosure of my information, photographs and images, which have not been previously published or disclosed by Kaerbear's Healthcare LLC. I understand that this withdrawal would not affect any non-Kaerbear's Healthcare LLC TV, radio, newspaper and other commercial media once they have received my information or recorded my image.
- Once my health information is disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.

Signature of Patient only: ______________________________ **Date:** ______________________________
(Required)

If you are NOT the patient but are signing on behalf of the patient complete the following:

I, ______________________________,
(print your name)

confirm that I am the legally appointed representative for the patient and I have CIRCLED my relationship to the patient below:

- **Parent with Parental Rights**
- **Registered Kinship Care Relative**
- **Court Appointed Guardian**
- **Legally Appointed Healthcare Agent**
- **Medical Power of Attorney**
- **Power of Attorney with Right to See Medical Records**
- **Surrogate Decision Maker**
- **Court Appointed Personal Representative of Deceased**

Representative's Signature: ______________________________ **Date:** ______________________________
(Required)

Address: ______________________________ **Phone:** ______________________________

You must attach proof of your authority to act on behalf of the patient as circled above (other than parent).

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