

AUTHORIZATION FOR RELEASE OF PERSONAL STORY

COMHAR is committed to protecting the privacy of your health care treatment and information. Because of this commitment and various State and Federal regulations, we must obtain your written authorization before we may use or disclose information about you for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed.

Please read the information below carefully before signing this form. This authorization for release of your personal story gives your consent to use of all or a portion of your personal story in all forms including media electronic, print, and other related promotion for the public display, dissemination and/or distribution of your identity such as a newsletter, COMHAR website, social media for informational or other purposes as determined by COMHAR.

I, _____, hereby understand, agree and authorize COMHAR, Inc. to use my personal story or a portion of my personal story and use my name, identity or other identifiable information, (“personally identifiable information”) at its discretion, for release, display, publication, dissemination or distribution to the public, including print media, newspaper, radio, television, or to the internet (such as the COMHAR website, social media, or any other COMHAR endorsed website) for the purpose of publicizing COMHAR and its services, marketing, public relations or other purpose at COMHAR’s discretion. I understand that release of my personally identifiable information will identify me to the general public as someone who receives services from COMHAR and/or identify the reasons for such services, especially if I allow COMHAR to disseminate or distribute an article written by me or a story about me that includes my challenges and success. I have the right to review and approve any information that pertains to my story or a portion of my story prior to its distribution.

This authorization expires only upon my written revocation.

Date of Authorization: _____ Expiration Date or Event: _____

Statement of Authorization:

I hereby authorize the use and/or disclosure of my personally identifiable or protected health information as described above. I have been informed and understand the following:

1. I have a right to revoke this authorization at any time by notifying COMHAR in writing. If I do revoke this authorization it will only affect release of future information. It will not apply to information already displayed, published, disseminated, or distributed by COMHAR in reliance upon my prior authorization, except for information that can be removed from COMHAR media managed by COMHAR such as the COMHAR website and COMHAR social media sites.
2. I understand that once my information has been released, COMHAR cannot guarantee that other individuals will not re-distribute it and it will no longer be protected.
3. I understand that my right to health care treatment will not be affected if I do not sign this authorization.
4. I have been informed of my right to examine/inspect any information. Any request to examine/inspect must be made at the time of signing this authorization, as COMHAR cannot guarantee the information will be available for review later.
5. I certify by my signature below that I understand the nature of this authorization and that all information contained herein has been explained to me and to my satisfaction.

Signature of Member/Designee and Date

COMHAR Witness Signature

COMHAR Witness Print Name

[] Copy offered/given to Member (HIPAA requires a copy be provided.)