AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

If you decline to give authorization, it will **not** affect your admission to or eligibility for any of the care community's programs. We value your privacy.

Resident Name: ______________________________

Address: ______________________________

City/State/ZIP Code: ______________________________

I agree that Lutheran Living Senior Campus and its management company may use and disclose the following information about me, whether or not it is health information:

> My first and last name; age; image, (photos, video, digital, artistic depictions); activities; and similar information that Lutheran Living Senior Campus may gather about me on social occasions or at events associated with Lutheran Living Senior Campus, to be used in Lutheran Living Senior Campus's annual and other reports, brochures and publications, videos and presentations describing the services of Lutheran Living Senior Campus, newspapers and via the internet, including, for example, Lutheran Living Senior Campus's websites, social media, third-party sites, and for any care-related or business purpose. This includes depictions of me using adaptive equipment such as a wheelchair, walker or cane, and oxygen.

This authorization is valid for ten (10) years from the date I sign it. I understand that I can change my mind about this authorization at any time by writing to the executive director of Lutheran Living Senior Campus. I understand that revoking this authorization will not change any use of my health information before the executive director receives my revocation, including my health information in all copies of newsletters and marketing materials already printed and my health information in stored digital media available on the internet.

I understand it is possible that once information, images, or recordings about me are used or shared by Lutheran Living Senior Campus, including health information, other people may share it, and I will not hold Lutheran Living Senior Campus responsible if they do.

I understand that a copy of this authorization is as valid as the original with my signature on it.

I am a (check one):

☐ Resident/Client

☐ Legal representative of resident/client (their name: ___________________________)

☐ Family member of resident/client

Resident Signature: ______________________ Date: __________

Resident Printed Name: ______________________

AND/OR

Signature: ______________________ Date: __________

(Authorized Representative OR Parent/Guardian)

Printed Name: ______________________ Phone: __________

Relationship to Resident/Client: ______________________

Witness required for signature by resident and/or legal representative or family member

Witness Signature: ______________________ Date: __________

Printed Name: ______________________

Title: ______________________

DECLINE

Resident Signature: ______________________ Date: __________

Resident Printed Name: ______________________

AND/OR

Signature: ______________________ Date: __________

(Authorized Representative OR Parent/Guardian)

Printed Name: ______________________ Phone: __________

Relationship to Resident/Client: ______________________

Witness required for signature by resident and/or legal representative or family member

Witness Signature: ______________________ Date: __________

Printed Name: ______________________

Title: ______________________