versiti™

Patient/donor code_____

PUBLIC DISCLOSURE OF HEALTH INFORMATION

PLEASE PRINT THE FOLLOWING INFORMATION:

Name(s) being featured in testimonial	Contact Person	Street Address	City	State	ZIP

Date of Birth	Email Address	Home/Cell Phone	Work Phone

I HEREBY AUTHORIZE VERSITI, INC., AND ITS AFFILIATES ("VERSITI")TO USE AND DISCLOSE MY HEALTH INFORMATION IN THE FORM OF:

- **My Testimonial**
- **Photos, Videotapes, Digital or Other Images of Me**

Other [*insert description*]: _____

TO: Versiti, 638 N. 18th Street Milwaukee, WI 53201

FOR THE FOLLOWING PURPOSE(S):

☐ **For Publication in Versiti materials for Marketing and Fundraising Purpose(s). Such Materials include internal documents, brochures, posters, billboards, print ads, newsletters, signage, video productions, television, radio and internet promotion and other marketing/fundraising materials.**

For Publication by an Outside Organization for its own Marketing Purpose(s) [insert description]: _____

_____

For Publication by the News Media [*insert description*]:_____

_____

- **For Interviews of Versiti Workforce Members by the News Media [*insert description*]:**_____

_____

Other [*insert description*]:_____

IF THE USE AND DISCLOSURE IS FOR MARKETING, PLEASE BE AWARE THAT VERSITI.

Does NOT receive any direct or indirect remuneration (i.e., something of value such as a monetary payment, a free item or service or other benefit) from a third party as a result of obtaining this Authorization.

Does receive direct or indirect remuneration (i.e., something of value such as a monetary payment, a free item or service or other benefit) from a third party as a result of obtaining this Authorization.

REDISCLOSURE NOTICE: As the disclosure of my health information will be made to the public, it is possible, and even likely, that my health information will be redisclosed and no longer protected by Federal health care privacy laws.

I understand that if I agree to sign this Authorization, which I am not required to do, I shall be provided with a signed copy of this Authorization. I understand that this Authorization is voluntary and that I may refuse to sign this Authorization. Unless allowed by law, my refusal to sign this Authorization will not affect my ability to obtain treatment, receive payment, enroll in a health plan or be eligible for benefits. I understand that to cancel this Authorization written notification must be presented to: Versiti Inc., Attn: Corporate Marketing, Team Lead Corporate Marketing Operations 638 N. 18th Street, P.O. Box 2178, Milwaukee, WI 53201-2178. I understand that my withdrawal will not be effective as to uses and/or disclosures of my health information already made in reliance on this Authorization.

EXPIRATION DATE: This Authorization is valid until the following date(s)/events: _____
If no date or event is specified, this Authorization will expire five (5) years from the date signed.

I have had an opportunity to review and understand the content of this Authorization. By signing this Authorization, I am confirming that it accurately reflects my wishes.

Signature of Patient/Recipient/Donor/Legal Representative and Relationship thereto	Date
	Date