Participating in Atrium Health Communications and Marketing

Atrium Health is committed to improving health, elevating hope, and advancing healing for everyone. Sharing your patient story can help us achieve that goal. Out of respect for your privacy and other rights, we would like your permission to use your health information and your images. Please review the below forms, and sign and date each of them as appropriate. If you have questions or concerns, please call our Corporate Communications, Marketing & Outreach department at 704-631-0930.

1. **For Patients Only:** If you are patient or the patient's parent/guardian/personal representative and you are giving us permission to use and disclose the patient's information, please sign and date the ***Authorization to Use and Disclose Information for Communication and Marketing***.

2. **For All Relevant Persons:** If you are giving us permission to use your image, likeness, and other forms that are unique to you in our marketing and communications materials (even if you are not a patient), please sign and date the ***Permission to Use Likeness*** form.

We appreciate your willingness to help us tell the story of Atrium Health and the work that we do every day to improve lives. Thank you!

Authorization to Use and Disclose Information for Communications and Marketing

This form authorizes us to use and disclose your patient/health information as described below.

Full Patient Name: _____ **Date of Birth:** _____

Who can use and disclose patient information	Atrium Health (including its Corporate Communications, Marketing & Outreach department and contractors), and its associated foundations, entities, affiliates, and locations (collectively, "Atrium Health")
Types of patient information we can use and disclose	You give Atrium Health permission to use and disclose any health information in any form (print, photograph, audio/oral, interview, video, digital, televised, posted, streamed, and other electronic forms), that we think is relevant about you and your health care, including your name, age, city of residence, illness/injury, your story, how we cared for you, and your image, including any photographs, videos, or recordings in which you appear.
What we can do with your information (purpose)	Atrium Health can use and disclose your information to share your patient story internally and externally, to market Atrium Health and promote our services, to educate others about health issues and care, and to publish articles and give presentations. We may communicate your information in newspapers, magazines and other publications; radio, podcast, and television broadcasts; internet and intranet sites; marketing and public relations materials/publications; social media outlets; and in patient or public education materials and brochures.
With whom we can share your information	Atrium Health can disclose your information to: local, regional, or national media outlets, including on social media; the public; Atrium Health marketing and communication recipients; associated Atrium Health Foundations; and other third parties designated by Atrium Health.
How long this Authorization lasts	This Authorization will expire when Atrium Health no longer needs the information. Please note that uses and disclosures involving your information made or issued before the expiration date cannot be retracted, especially if they were already released publicly.

Please also understand that:

- Refusing to sign this form will not interfere with your ability to receive treatment, payment, enroll in our health plan, or be eligible for benefits from Atrium Health if available.
- You can cancel this Authorization at any time by sending written notice to Atrium Health Corporate Communications, Marketing, and Outreach, PO Box 32861, Charlotte, NC 28232-2861. Cancellations will apply only to information not yet used or disclosed by Atrium Health. Note that once Atrium Health uses and discloses your information, the person or entity receiving it may disclose or share that information with others and it may no longer be protected by federal and state privacy protections.
- Atrium Health will not share or use your health information without your authorization other than as required by law or in the ways listed in the Atrium Health Notice of Privacy Practices, available at www.carolinashealthcare.org.
- You have a right to receive a copy of this form upon request.

Signature: _____

Patient Name: _____ Date: _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form. Note the relationship/authority if signature is not that of the patient (Written Proof May be Requested):

☐ Healthcare Agent/POA ☐ Guardian ☐ Executor/Administrator/Attorney in Fact ☐ Spouse
☐ Parent ☐ Adult Child ☐ Affidavit Next of Kin ☐ Other: _____

Patient Label

Permission to Use Likeness

This form gives us permission to use your stories, image, voice, etc. under intellectual property laws. It is separate from the Authorization, which gives us permission to use and disclose your information under patient privacy laws.

I grant The Charlotte-Mecklenburg Hospital Authority d/b/a Atrium Health and its associated foundations, even if separately incorporated (collectively, "Atrium Health") a perpetual, world-wide, royalty free license and permission to record, use, disclose, portray, reproduce, broadcast, stream, post, print, and publish my (or the person on whose behalf I am serving as a personal representative, who will be included in the terms "my", "me", "mine", or "I") likeness, picture, video, information (including that released pursuant to an Authorization), story, quotes, and interview, whether in digital, electronic, paper, print, video, oral, or televised form ("Information") for Atrium Health's current or future internal and external marketing, fundraising, public relations, and educational purposes on behalf of Atrium Health (including on behalf of its hospitals, practices, programs, and associated foundations). I understand that such Information will be the exclusive property of Atrium Health, free and clear of any claim on my part and may be used in future video or print projects, in whole or in part.

I understand that I will not be compensated for the permissions, licenses, or use of the Information. I also understand that Atrium Health is only responsible for its own actions, and does not control third parties, including other media outlets. I understand that I can request that production of the recording be stopped at any time during production and I can revoke this Permission before the Information is used. On behalf of myself, my child, our heirs and representatives, I agree to release Atrium Health, their commissioners, directors, officers, and employees, from and against any liability related to their use of the Information.

Signature: _____

Patient Name: _____ Date: _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form. Note the relationship/authority if signature is not that of the patient (Written Proof May be Requested):

☐ Healthcare Agent/POA ☐ Guardian ☐ Executor/Administrator/Attorney in Fact ☐ Spouse
☐ Parent ☐ Adult Child ☐ Affidavit Next of Kin ☐ Other: _____

Patient Label