Permission to Use Your Information or Image for Promotional Purposes

SANFORD

Information about you and your health is personal. Sanford is committed to protecting the privacy of your information. When Sanford wants to share your information for the public to see or hear, we must ask for your written permission (authorization). If you let us share your private information, you can ask how it will be used. You can also ask to stop an interview, recording, film or photo session at any time. People will likely recognize you in a promotion or interview, so please read this form carefully and ask any questions you have before signing.

I, _____, give permission for Sanford Health, Sanford Marketing and Media Relations, and the Sanford Health Foundation or their representatives to use and share my health information for:

- ❑ Sanford promotional purposes through written, video, internet or any other means of publication
- ❑ Local and national media interviews or stories
- ❑ Learning/Educational purposes

Information about me to be used or shared includes:

- ❑ My appearance in photographs, videos, audios or any other image
- ❑ Information about me gathered by Sanford staff or news reporters through interviews with me, my physicians or any others involved in my. This information may include my name and my health condition(s) related to the Sanford promotion or media interview.

The information described above becomes Sanford's property or the property of the news media. Once your information is shared, it is no longer protected under federal and state privacy laws and may be re-disclosed or re-published by others in the future. Information published on the internet is available to anyone in the world and may be accessed, reproduced or downloaded at any time. Sanford will not receive payment of any kind for the use of your information. This permission does not include any promise to pay you.

Signing or refusing to sign this authorization will not affect your care at Sanford in any way. After you sign, you may change your mind at any time unless the information has already been used or shared. Please contact Sanford Marketing at 605-312-4300 if you change your mind and do not want your information to be used for new or future stories and promotions. This authorization will expire on _____, or five years from the date of signature if no date is entered.

Are you a current or former patient of Sanford Health? ❑ Yes ❑ No

_____ _____
Patient Name (please print) Date of Birth

_____ _____
Signature of Patient or Personal Representative Date Time

_____ _____
Name of Personal Representative (if applicable) Relationship to Patient

_____
Witness/Organization Representative

Comments:_____

Disbursement: Page 1 - HIM; Page 2 - Marketing

Name _____
Address _____
_____
Phone _____