adapt
Integrated Health Care

Adapt Integrated Health Care
P.O. Box 1121
Roseburg, OR 97470

541-672-2691
adaptoregon.org

AUTHORIZATION FOR USE OF HEALTH INFORMATION FOR MEDIA PURPOSES

Purpose of this Form:

Adapt, Inc. (dba Adapt Integrated Health Care), herein referred to as "Adapt," "we," "us," "the agency," is committed to protecting the privacy of your health information. The Health Insurance Portability and Accountability Act (HIPAA) gives you protections regarding the use and release of your health information, in addition to those protections that already exist under Oregon law. This federal law requires that we give you this authorization form for your review and signature.

Authorization to Use Health Information:

This authorization allows us to discuss your case and treatment with parties creating articles, broadcasts, films, or promotional materials to communicate or market our health services. This may involve newsletters, website content, social media, annual reports, and more. You acknowledge that you might be photographed, filmed, or voice-recorded by our representatives or media personnel directly. Your name, image, or other identifying details may be disclosed.

By signing this, you forgo any compensation rights and release us from any claims related to the use or display of your identity in any publication. While we won't use or disclose your health information for other purposes without explicit authorization, note that this disclosure is for media purposes, and upon such disclosure, federal privacy protections may not apply.

How long will this authorization be in effect?

This authorization will remain in effect for a period of five (5) years from the date of my signature below. Once your authorization expires, we may need your signature again.

What if I don't want to sign, or later change my mind?

Signing this form is voluntary. Not signing this form will not affect the commencement, continuation, or quality of our treatment of you, or your eligibility for benefits.

In the event you wish to revoke your approval, we will redact/remove all explicit identifiers (name, likeness, titles, etc.) from the designated publication effort. For any requests received that would be for third-party publications (e.g., news outlets, media organizations, etc.), we will make redaction requests; however, redaction requests submitted to third parties are not enforceable by us and may or may not be removed at the discretion of the outlet.

You may revoke this authorization at any time by sending a written notice to the Adapt Compliance Department stating that you are revoking your authorization. The notice should be sent to the below address, and you may call (541) 492-0129 for more information.

ATTN: Compliance Department
621 West Madrone Street
Roseburg, OR 97470

By signing below, I affirm that I have read and understand the terms of this authorization and I have had an opportunity to ask questions about Adapt's use of my health information for possible use in broadcast or publication. I hereby knowingly and voluntarily consent to Adapt using my health information for the purposes stated herein.

Name ______________________________

Signature ______________________________

Date ______________________________

If the above-named is under 18 years of age, or otherwise unable to sign this authorization, a legal guardian must sign the below:

By signing below, I affirm that I am the legal guardian of the above-named participant and, on their behalf, have read and understand the terms of this authorization and have had an opportunity to ask questions about Adapt's use of their health information for possible use in broadcast or publication. I hereby knowingly and voluntarily, on behalf of the above-named, consent to Adapt using the above-named participant's health information for the purposes stated herein.

Name of Legal Guardian ______________________________

Legal Relationship ______________________________

Signature ______________________________

Date ______________________________