uchealth

AUTHORIZATION FOR UCHEALTH TO USE OR DISCLOSE HEALTH INFORMATION FOR MARKETING/MEDIA PURPOSES IN CONJUNCTION WITH THE COLORADO EAGLES FIGHT CANCER HOCKEY GAME

Name: _____

Nominee (Name) First_____ Last_____

Address: _____ City/State: _____ Zip: _____

Email: _____ Phone Number: _____

I understand UCHealth and its affiliated entities (collectively "UCHealth") wish to use and/or disclose my name and the fact that I am a cancer patient/survivor/honoree for marketing/media related purposes. My health information used and/or disclosed for this purpose will include my full name and the fact that I am a cancer survivor/patient/honoree. My name will be displayed with other honorees as a part of a 'cancer warrior' tribute on one of the 2 UCHealth dasher boards at the Eagles Fight Cancer Hockey game on 1/25/20 at The Budweiser Events Center.

By signing this authorization, I am allowing UCHealth to use and/or disclose my health information and as indicated above unless I have specifically limited UCHealth's use or disclosure of my health information as follows: (Note: leave blank if no further restrictions)

_____

I acknowledge that I am not required to sign this authorization and that I am signing this voluntarily. If I am a patient, or become a patient, of UCHealth facilities or clinics, I understand that my health care and payment for my health care at UCHealth will not be affected by whether or not I sign this authorization. I may revoke this authorization at any time by notifying the UCHealth Marketing and Communications Department in writing of my decision to revoke at Dan.Luce~~Privacy~~@uchealth.org. Any revocation will not apply to my health information that has already been used and/or disclosed as a result of this authorization. I understand that if my health information has been disclosed to someone who is not legally required to keep it confidential (i.e., a news station or the public on the dasher board), that information may be re-disclosed and is no longer protected by state and federal privacy laws.

Field Code Changed

UCHealth may receive direct or indirect remuneration as a result of its use of my information. This authorization is valid for 10 years unless I revoke it in writing prior to that time.

I have read this authorization, understand its terms, and agree to UCHealth's use and/or disclosure of my health information as stated herein.

_____	_____	_____
Name of Patient/Patient's Legal Representative	Signature of Patient/Patient's Legal Representative	Date

*Legal Representative (e.g. parent, etc.) signature required for individuals under 18 years of age.