Virginia Mason Memorial

I,_____(name of patient), do hereby authorize Virginia Mason Memorial to use and/or disclose health information about me, as specified below, to:

- Reporters for local, state and national media outlets, including newspapers, magazines, television broadcast stations, radio stations, internet and social media sites.
- The Virginia Mason Memorial communications/marketing department or anyone authorized by Yakima Valley Memorial Hospital for marketing and promotional purposes.

By initialing the spaces below, I specifically authorize the use and/or disclosure of the following health information:

____All photography, video, audio, and/or printed testimonial taken from me on the date of this release.

____Information about my specific injuries or medical condition

____My prognosis

____My age

____My city, county or state of residence

____The date and time of my expected or actual discharge from the hospital

____Information necessary to conduct an interview with me at the hospital

I understand any and all reproductions of materials including my image, voice, condition (as outlined above) or personal testimony obtained on the date of this release remains the property, solely and completely of Virginia Mason Memorial, to be used exclusively for the promotion of Virginia Mason Memorial and its family of services without further compensation to me.

I understand that by signing below I am voiding any previous elections to "opt out" of releasing my health information for the express purpose(s) outlined above.

I understand that media representatives are not covered by federal privacy regulations and my health information may be disclosed and no longer protected by these regulations.

I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

Finally, I do understand that I may revoke this authorization at any time, provided that I do so in writing. I understand that information released between the effective date of this authorization and the date of the revocation may still be used in the public domain.

_____

Print Patient(s) Name Date

_____

Signature of Patient or Patient's Representative (Parent/POA)

_____

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