

40 Acts of Service

Patient, Community Participant, & Employee Authorization for Disclosure of PHI, Use of Image, Volunteering, and Hold Harmless

Part A: Completed by a DCI patient

I, _____, am a patient at the Dialysis Clinic, Inc. (“DCI”) clinic located at _____ (“Clinic”). I understand that DCI desires to videotape, photograph, and/or possibly interview me and may disclose my name, age, dialysis location and health history. (Example - Patient Name, intern, DCI, 51 yrs. old, 22 years dialysis at Clinic Name, high blood pressure and diabetic). The videotape/photographs and interview may be used for the following:

- Promoting DCI through media outlets including but not limited to television, radio, trade magazines, newspapers, and billboards;
- DCI’s Intranet and Internet websites;
- Patient education videos to be shown in the Clinic or at DCI company meetings;
- Public information representing DCI and it’s services at events, such as, but not limited to Trade Shows, Job Fairs and Health Fairs;
- Pre-ESRD/ESRD patient education to be shown at physician offices, hospitals, health fairs, or other venues offering pre-ESRD/ESRD patient education within the 50 states; and/or
- Other educational uses for DCI.

I understand and agree that videotape/photographs taken of me are the property of DCI and I relinquish any rights that I may have to said videotape/photographs. Furthermore, I understand that there will be no financial compensation for my interview or appearance in the videotape/photographs or websites cited above.

The purpose of taking the videotape/photographs has been explained to me and I hereby authorize DCI to videotape/photograph and interview with me for the purposes specified above.

DCI will not condition my right to treatment or payment on granting this requested authorization. I have the right to refuse to sign this authorization. Except to the extent that DCI has already relied on it, I have the right to revoke this authorization by doing so in writing addressed to the following person:

Privacy Officer – DCI Corporate
1633 Church St. Suite 300
Nashville, TN 37203

A photocopy of this authorization shall have the same force and effect as the original.

This authorization remains in effect until the videotape/photographs are destroyed.

I understand and accept that the information used or disclosed under this authorization may be subject to redisclosure by DCI and would no longer be protected by Federal and State Privacy and Security regulations afforded me.

I also acknowledge that my participation in this event is entirely voluntary and I do so at my own risk.

I certify that I have read (or had read to me) the above authorization and that I fully understand the nature and purpose of this authorization. I have had the opportunity to ask and have answered any questions that I may have regarding the information contained in this authorization form. I also certify that I am the patient or the patient's duly authorized agent or representative and that I am authorized to execute this authorization.

Signed: _____
(Patient Signature)

Date: _____

(Print Patient Name)

*(Personal Representative of Patient)

Witness: _____

Date: _____

*** Must obtain a copy of the legal document granting authority to sign for patient.**

Part B: *Completed by a community participant or DCI employee*

I, _____, understand that my participation in this event is entirely voluntary and I will not be compensated.

I also understand that I participate at my own risk. I agree to release and hold DCI harmless for any loss, damage, or injury related to my participation in this program.

I further acknowledge and agree that DCI may use my image, and general/personal information to promote DCI and/or the 40 Acts of Service program and I will not be compensated for its use.

Signed: _____

Date: _____

(Print Name)

Authority of Personal Representative
if signing for a minor

If employee, clinic name

E-mail address to receive follow up
information (will not be publicized)