QuadMed

AUTHORIZATION FOR PUBLIC DISCLOSURE OF MEDICAL INFORMATION

Patient Name: _____ DOB: _____ MRN: _____

I authorize Quad/Med, LLC and its representatives, agents, and associated providers ("QuadMed") to use and disclose information about me in commercial, marketing, and promotional materials of any kind. This information may include medical information, my image, including full-face or other body images of me, other photographs or likeness, videos, and testimonials, name, and other biographical information. I understand these materials may be, without limitation, used in marketing, promotional, or informational materials in any media, posted in the health center, and released to the general public worldwide and/or posted on the internet. I understand that some or all of this information may be protected health information ("PHI") that is protected by health care privacy laws. I also understand that QuadMed may receive remuneration from a third party as a result of obtaining this authorization.

MY RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

This Authorization is Voluntary. I understand this authorization is voluntary. Unless allowed by law, my refusal to sign this authorization will not affect my ability to receive treatment from QuadMed or associated health care providers. I also understand my refusal to sign this authorization will not affect my eligibility for or ability to enroll in my employer's health plan benefits. I understand that it is possible, and even likely, that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by applicable privacy laws.

Right to Revoke this Authorization. I understand that I have the right to revoke this authorization at any time in writing. My revocation will not apply to uses and disclosures that have already occurred under this authorization. I understand that my revocation is effective only if it is in writing. To revoke my authorization, I understand that I must send a written request for revocation to QuadMed, Attention: Privacy Officer, N64W23110 Main Street, Sussex, WI 53089.

Right to Inspect and Copy. I understand that I have the right to inspect or obtain a copy of the PHI I have authorized to be used and/or disclosed by this authorization.

Right to Receive a Copy of this Authorization. If I agree to sign this authorization, which I am not required to do, I will be provided with a signed copy of this form.

Expiration. This authorization expires at the termination of the commercial, marketing, promotional or other public relations activity, campaign and/or event in which I have

agreed to participate, or ten (10) years from the date of my signature below, whichever is later.

NEW YORK RESIDENTS: If you are authorizing the release of HIV-related information, the recipient(s) is prohibited from redisclosing any HIV-related information without your authorization unless permitted to do so under federal and state law. If you experience discrimination because of the release or disclosure of HIV-related information, you may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting your rights.

I have had an opportunity to review and understand the content of this authorization. By signing below, I am confirming that it accurately reflects my wishes and that I authorize QuadMed to use and disclose my PHI in accordance with the terms and conditions above.

Signature of Patient or Personal Representative	Relationship to Patient (Legal Authority)