RESIDENT AUTHORIZATION & RELEASE TO USE PHOTOGRAPH & PERSONAL INFORMATION

I hereby voluntarily authorize ______________________________ ("Facility") to release information about me under the terms and conditions described below.

1. I authorize the Facility to photograph me and to provide images of me along with my name and the fact that I reside in the Facility to the Skilled Nursing Care Coalition and its members (associations).
2. I authorize the Facility to release the following information about my health care condition and the types and extent of nursing care services that I require to the Associations:

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   (collectively, the information described in section 1 and 2 of this Authorization is referred to as "My Information").
3. I authorize the Associations to use My Information for marketing and lobbying efforts in an attempt to improve federal and state reimbursement to nursing facilities in Ohio, and to educate the community regarding life in a skilled nursing facility.
4. This authorization is voluntary and I understand that the Facility cannot condition treatment based on the signing of this authorization, unless the authorization is (a) for research-related treatment, or (b) solely for the purpose of creating health information for the use or disclosure to a third party.
5. This authorization will never expire, unless I revoke it.
6. I understand that I may revoke this authorization at any time by notifying the Facility in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
7. I understand and agree that the Facility and the Associations will not pay or provide compensation of any kind for the images that are taken.
8. I understand and agree that I will not have the ability to approve or disapprove of any images that are taken or recorded, and that the sole discretion regarding which images to use and how to use them will rest with the Associations.
9. I understand and agree that by signing this authorization form I am waiving my rights to any images that are taken, and that such images will become owned by the Associations. Thus, I authorize the Associations to copyright my images or any media containing my images in their name or in any other name(s), and to use and distribute such images and documents in any manner they desire for their marketing and lobbying purposes.
10. I authorize the Associations to modify or alter any images, such as by reducing or increasing their size.
11. I understand that once My Information is released it will not be subject to any privacy protections afforded by the Facility if the recipient of the information is not a health plan, health care provider, health care clearinghouse, or a business associate that has a contract with the Facility.
12. I, on behalf of myself, and my heirs, executors, administrators, successors, assigns, and any other person or entity claiming by or on my behalf, agree to waive all claims and causes of action against the Facility, the Associations and their past, present and future officers, directors, members, agents, representatives, partners, affiliates, attorneys, subsidiaries, predecessors, successors and assigns related to, arising out of, or in connection with the use and/or disclosure of My Information for the purposes identified in this Authorization.

______________________________	______________________________	__________
Signature	Print Name	Date