



MEMBER AUTHORIZATION AND RELEASE For Promotional and Educational Activities

Return Original to:
CountyCare Compliance
1900 W. Polk, Suite 227A
Chicago, IL 60612

Member Last Name			Member First Name			Member Middle Name		
Recipient Identification Number					Email Address			
Birth Date	Month	Day	Year	Today's Date				
Address			City	State	Zip	Phone		

I give permission to the CountyCare Health Plan to use my personal information, photo/image, and/or voice recording, in any medium, for educational, promotional, fundraising, advertising, marketing, legal or other purposes that support the mission of CCHHS and CountyCare Health Plan.

- Personal information about me may include my: name, age, medical conditions, care coordination information and experience, diagnoses, city and state of residence, photograph, location of care received, information about my life, and my experience with CountyCare as a health plan.
- My personal information may also be disclosed to external media (including websites) in the form of press releases, stories, articles, brochures, photographs, or video/audio clips. It may also be used for internal purposes or on the CountyCare website or through CountyCare's own marketing or educational campaigns.
- I also understand that CountyCare may hire third parties to capture my image and/or voice, and that my information will be used and disclosed by these third parties as instructed by CountyCare.
- CountyCare and I will not receive any direct or indirect payment from or on behalf of any third party in exchange for the release of this information about me.

CountyCare will make all reasonable efforts to protect my confidentiality. However, I understand the information I provide subsequent to this authorization may be re-disclosed by CountyCare and no longer protected by state or federal privacy laws. By checking the box(es) below, I give permission for CountyCare to use my information as outlined above only to the extent that it is:

- De-identified (i.e., use of removal of key identifiers such as name, birth date, voice, and full-face photographic or comparable images, other unique identifying number, characteristic, or code, etc.)
- Pseudonymized (replacement of my real name with a fictitious name)
- Other – Please list the type of information that you do not want disclosed:

- This authorization will expire:
- Ten (10) years from this date
 - Other _____
 - I revoke the permission originally granted

By signing this authorization, I expressly release from liability all personnel of CountyCare, as well as their successors and assigns, and all persons acting under their permission or authority. I understand that CountyCare may not condition my enrollment in CountyCare or my eligibility for benefits on whether I sign this authorization. I may revoke this authorization at any time by submitting a notice in writing to CountyCare Compliance or returning this form with the appropriate box checked.

Signature of Member	Date
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FOR PARENTS/GUARDIANS/AUTHORIZED REPRESENTATIVES OF THE MEMBER

I hereby certify that I have the legal authority under applicable law to grant this authorization and make this request on behalf of the member identified above. If the member is a minor or has a personal representative, I represent that I am the legal parent/guardian/personal representative of the member named above and I am not prohibited by Court Order from releasing access to the requested information.

Name of Authorized Representative	Relationship to Member
Signature of Parent/Guardian/ Authorized Representative	Date