Authorization for the
Use and Disclosure of Personal Identifiable Information

I, the undersigned, authorize the use and/or disclosure of my personal identifiable information ("PII") as described below:

1. I authorize Baylor Institute for Rehabilitation and its affiliated covered entities, and the members of their medical staff and allied health staff ("Baylor"), to disclose to members of the allied health and marketing staff of Baylor involved in the presentation and marketing of support groups and other patient support activities on behalf of Baylor Institute for Rehabilitation, PII and information about me, including my physical or email address, other demographic information and contact information, and my diagnostic category for purposes of making available to me, in print or electronic media, any publicity, advertising, marketing, promotion, education or publication regarding events, meetings or other educational or patient support activities that Baylor determines may be of interest to me. My authorization is limited to members of the allied health and marketing staff of Baylor and does not include disclosure of PII to outside organizations or agencies. My authorization is limited to the disclosure of my physical or email address, other demographic information and contact information and my diagnostic category and only this PHI may be used and/or disclosed pursuant to this authorization.

2. This authorization expires ❑ when I revoke this authorization; ❑ 1 year; or, ❑ other _____. If blank, this authorization is valid for 180 days.

3. I understand that once my PII is used and/or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient(s) and no longer protected by applicable privacy laws

4. I understand that I have the right to revoke this authorization at any time. My revocation must be in writing as described in the Notice of Privacy Practices. I am aware that my revocation is not effective to the extent that I have authorized the use and/or disclosure of my protected health information and such use and/or disclosure have been relied upon by authorized recipients. To revoke this authorization, I must notify Baylor Institute for Rehabilitation's Public Relations department at 214-820-9330.

5. I understand that I have the right to inspect or copy the PII to be used or disclosed and I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Baylor nor will it affect my eligibility for benefits.

6. Please send invitations to me by (box) email at _____ and/or (box) mail at

_____

_____
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE

_____
Printed name of person signing the document

_____
WITNESS SIGNATURE DATE

If signed by a personal representative, describe what authority you have act on behalf of the person whose information is being released:

Please return completed Authorization form to:
Baylor Institute for Rehabilitation
Therapeutic Recreation Department
Attention: Lea Goad
909 North Washington Avenue, Suite 106
Dallas, Texas 75246