LUTHERAN Community Services NORTHWEST

Health. Justice. Hope.

Lutheran Community Services Northwest
Authorization and Release Form
for Marketing and Communications

– updated for photos only –

It is important that Lutheran Community Services Northwest (LCSNW) shares stories of our patients, clients and participants. These stories help us promote health, hope and justice. LCSNW respects the privacy of our patients, clients and participants.

LCSNW seeks your permission to use your photo and/or information about you in stories, photographs or videos. That image or information could be used for internal, external, fundraising and news media communications in print and digital formats. You may revoke the future use of your information at any time by notifying us in writing.

To ensure that LCSNW is acting in accordance with your wishes, please fill out this form so we can use your personal information with your authorization. We will keep a copy of this agreement.

1) I am signing this authorization form voluntarily. LCSNW does not condition treatment, payment, benefit eligibility, or enrollment activities on the signing of this form. I understand that I will not be entitled to any payment or any other form of compensation as a result of any information and audio/video/photographic material. If I sign this form, I have the right to request that audio/video recording, filming or photography stop at any time.

2) I am aware that my image and/or information will exist forever in a recorded, printed and/or electronic version(s), and that once published or disclosed in any form, it will continue to be used. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient.

3) I understand that I may revoke or withdraw this permission at any time to prohibit future use of my information by sending written notice to LCSNW, Communications Director, 4040 S. 188th St., Suite 300, SeaTac, WA 98188. I understand that LCSNW will retain copies of any such electronic or printed versions and shall retain these versions. Any revocation of this authorization will only extend to the versions of the information within LCSNW's control that have not been previously published. If not revoked/withdrawn by me, this authorization expires 10 years from the date that I sign it.

I give permission for LCSNW to use my name. Any specific information or instructions include: _____

☒ LCSNW may use this information for internal and external LCSNW print and digital publications, and may include fundraising and marketing material. Any restrictions include: _____

☐ LCSNW may release my name to the news and/or electronic media. Any restrictions include: _____

Patient/Client/Participant Name: _____
(first) (m. initial) (last)

Signature: _____ **Date:** _____

Address: _____
(street address) (city) (state) (zip code)

Phone: _____ **Email:** _____

For personal representatives, please provide the following:
I, (name:) _____ ,represent that I am the ☐ health care agent* ☐ guardian* ☐ parent of the patient / client / participant above.

Personal Representative Signature: _____

Address: _____ Phone: _____

*If you are the health care agent or guardian, please provide proof of your authority to act on behalf of the patient

Please initial if these apply:

___ I specifically authorize the release of information pertaining to mental health diagnosis or treatment.

___ I specifically authorize the release of information pertaining to alcohol, drug and or substance abuse, diagnosis or treatment.

___ I specifically authorize the release of information pertaining to HIV/AIDS test results.

LUTHERAN Community Services NORTHWEST

CONFIDENTIALITY AGREEMENT

For Volunteers

As a volunteer of LCSNW, I may have access to confidential information including client, financial or business information obtained through my association with LCSNW. The purpose of this Agreement is to help me understand my obligations and obtain my agreement to comply with these obligations regarding confidential information.

Confidential information is valuable. sensitive, and is protected by law and by strict LCSNW policies. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires protection of confidential Information contained within information systems. Inappropriate disclosure of client data may result in the imposition of fines up to $250,000 and ten years imprisonment per incident.

Accordingly, as a condition of and in consideration of my access to confidential information, I assert the following:

1. I will not access confidential information for which I have no legitimate need to know and for which I am not an authorized user.
2. I will not in any way divulge, copy, release, sell, loan, review, alter, or destroy any confidential information except as properly authorized within the scope of my job responsibilities.
3. If I observe or have knowledge of unauthorized access or divulgence of confidential information, I will report it immediately to my supervisor or to the HIPAA Privacy and Security Officer (hipaa@lcsnw.org).
4. I will not seek personal benefit or permit others o benefit personally by any confidential information that I may have access to or that I access as an unauthorized user.
5. I understand that all information, regardless of the media on which it is stored (paper, computer, videos, recorders, phones, etc.), the system which processes it (computers, voice mail, telephone systems, faxes, etc.), or the methods by which it is moved (electronic mail, face to face conversation, facsimiles, etc.) is the property of LCSNW and shall not be used inappropriately or for personal gain.
6. I will not remove any confidential information from LCSNW.

I understand that my failure to comply with this Agreement may result in disciplinary action, up to and including termination of association with LCSNW, the imposition of fines pursuant to relevant state and federal legislation, a report to my professional regulatory body and/or legal action.

I understand that the obligations contained in this Confidentiality Agreement will continue after my association with LCSNW ends.

Volunteer Signature: _____ Date_____

Printed Name: _____

Revised 5.13.25