CareLinc Medical Equipment & Supply

PATIENT MEDIA, STORY & MARKETING AUTHORIZATION

Permission to use photographs, video, audio, testimonials, stories and related information

Your privacy matters. Signing this form is voluntary. Your decision will not affect your care, services, benefits, payment, or eligibility to receive equipment or services from CareLinc.

1. What I authorize CareLinc to use

I authorize CareLinc Medical Equipment & Supply and its authorized representatives to photograph, film, record, interview, collect, reproduce, edit, publish, display, distribute, and use the items I approve below (collectively, "Materials"):

☐ Photograph/image	☐ Video recording	☐ Audio recording
☐ First name	☐ Full name	☐ Written/recorded testimonial
☐ Comments, quotes or story	☐ CareLinc experience	☐ Other: _____

CareLinc will not intentionally disclose medical records or health information beyond information specifically included in the Materials or information I voluntarily provide for this purpose.

2. How the Materials may be used

I authorize CareLinc to use the Materials for legitimate business purposes, including communications, education, marketing, community outreach, public relations, recruiting, and promotion through:

- CareLinc websites, resource pages, social media, digital advertising, email, and other online channels.
- Printed brochures, flyers, posters, newsletters, displays, presentations, conferences, trade shows, community events, and educational materials.
- Media relations, press releases, community partnerships, internal employee communications, and training materials.

I understand that public content may be viewed, copied, downloaded, shared, or redistributed by others outside CareLinc's control.

3. HIPAA authorization and privacy rights

Some Materials may identify me as a CareLinc patient/customer or may contain protected health information (PHI). By signing this form, I authorize CareLinc to use or disclose the PHI specifically included in the Materials for the purposes described above.

- I understand that information disclosed publicly under this authorization may no longer be protected by HIPAA and may be redisclosed by others.
- Signing this authorization does not waive my other HIPAA rights.
- CareLinc will not condition treatment, equipment, services, payment, enrollment, or eligibility for benefits on whether I sign this authorization, except as otherwise permitted by law.
- I may request a copy of this signed authorization.

Read your HIPAA rights and CareLinc Notice of Privacy Practices

carelincmed.com/hipaa-privacy-policy

You may also request a paper copy at any time.

4. Voluntary participation, compensation and editing

I understand that participation is voluntary and, unless CareLinc agrees otherwise in writing, I will not receive payment, royalties, compensation, or other financial benefit from CareLinc's use of the Materials. CareLinc may edit, crop, format, caption, or combine the Materials with other content, provided the resulting use does not materially misrepresent my statements or experience.

5. My right to revoke this authorization

I may revoke this authorization at any time by submitting a written request to CareLinc. Revocation will apply to future use when reasonably possible and will not undo uses or disclosures already made in reliance on this authorization. Materials already printed, distributed, published, shared, or reproduced by others may not be capable of being recalled or removed.

Send revocation requests to:	**Questions or privacy concerns:**
HIPAA Compliance Officer, CareLinc 89 54th St SW, Grand Rapids, MI 49548	616-249-2273

6. Authorization and signature

By signing, I confirm that I have read and understand this authorization, had an opportunity to ask questions, understand that signing is voluntary, and authorize CareLinc to use the Materials as described above.

Representative must sign ***only*** when the individual cannot legally provide authorization on their own. Signer certifies that they have legal authority to provide this authorization on behalf of the individual identified here.

Patient/Individual Name: _____ Date of Birth: _____

Signature: _____ **Date:** 08/28/2026

Phone: _____

Parent/Guardian/Personal Representative Name: _____

Representative Signature: _____ **Date:** 08/28/2026

Relationship to patient/individual: _____

Clear Form