Willamette Valley Cancer Institute and Research Center (WVCI)

PATIENT MEDIA RELEASE

In signing this release, I hereby allow the use of my image, voice and comments by Willamette Valley Cancer Institute and Research Center, McKesson Corp., and each entity's subsidiaries, affiliates. I understand that I may refuse to sign this authorization and that it is strictly voluntary.

I agree to waive all rights to and allow the use of my image, voice and/or comments for advertising and marketing purposes. This includes but is not limited to printed materials, videos, press releases, billboards, social media and/or Web site content. I understand that I may be identified through such use of my image, voice and/or comments.

I understand I can revoke my consent at any time, but once a project has been initiated in which my image, voice and/or comments are used, it will not be possible to revoke my consent for such use. Any prior or existing publication or uses will not be affected by my revocation of consent.

I hereby waive any right that I may have to receive any form of compensation or to inspect or approve the finished product or products and the advertising copy or other matter that may be used in connection therewith or the use to which it may be applied.

I hereby release, discharge and agree to hold harmless the above parties as well as any photographer and other persons or entities engaged by the above parties, their officers, legal representatives and assigns, all persons acting under their authority and any other party for whom they are acting from any and all liability, damages and claims, including but not limited to any claims for libel or invasion of privacy.

HIPAA AUTHORIZATION

MEDIA / PATIENT AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I hereby authorize McKesson Corporation, its affiliated practices and the employees or agents of any of those entities ("Disclosing Parties") to use and disclose my health information in the manner described below. I understand that my health information is expected to be re-disclosed by the persons or organizations receiving my health information from the Disclosing Parties, and that information disclosed in accordance with this authorization will no longer be protected by federal or state privacy laws. Disclosing Parties may not condition any treatment or benefit on whether I sign this authorization. I voluntarily sign this authorization, and I understand that my ability to obtain healthcare from the Disclosing Parties will not be affected if I refuse to sign this authorization. I understand that the Disclosing Parties will receive compensation (e.g., media exposure) for the use and/or disclosure of my health information I authorize.

1. I authorize the use and disclosure of my name, health information, and identifiers that *do **not** include* a social security or financial account number.
2. The health information described above will be used and/or disclosed for the following purpose(s):
   To allow the Disclosing Parties to draft press releases and story pitches, arrange and complete interviews, including videotaped or otherwise recorded interviews, related to my health care and treatment. The interviews and press releases are expected to contain information regarding my health history and treatment, and they are intended to be disclosed to third parties (not the Disclosing Parties or my family) who will prepare the interview material for further distribution including, e.g., via print publications, broadcast television, cable news shows, news syndication services, and Disclosing Parties' marketing efforts.
3. I authorize the Disclosing Parties to use and to disclose the health information as described above. I authorize the Disclosing Parties to answer questions and provide information about my treatment and health in support of the story, and participate in subsequent interviews during the effective period of this authorization.
4. Persons/organizations you are authorizing to *receive* the health information described above:

Members of the news media (including print publications, cable news shows, and broadcast television, including without limitation its employees and agents), news syndication services such as Pathfire Digital Media, and persons operating marketing campaigns on behalf of the Disclosing Parties (including without limitation any members of these parties' respective workforces present during any interview). I understand that these recipients include individuals and organizational units having no right to access to my protected health information other than through this authorization and no duty to safeguard such information, and I understand that they will re-disclose the material filmed or otherwise recorded in connection with the interviews.

5. This authorization expires ten years following participation in 2022. I understand that this expiration limits the authority of Disclosing Parties to make disclosures beyond those required to arrange and complete any interviews completed while this authorization remains in effect, but does not limit use or disclosure of interviews recorded in reliance on this authorization. The termination of this authorization does not affect potential re-disclosure by recipients of information disclosed while this authorization is in effect.
6. I understand that I may revoke this authorization at any time by notifying the Disclosing Parties in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my health information have acted in reliance upon this authorization. I understand that I have a right to request and receive a Notice of Privacy Practices from the Practice.

_____ _____

Signature of Patient Date

If this authorization is signed by a patient's personal representative on behalf of the patient, please complete the following:

_____ _____

Name of Personal Representative Relationship to Patient