District 3 Queen Pageant

Authorization for Disclosure and Use of Information

I voluntarily authorize the use or disclosure of the individually identifiable information I provide in connection with the AHCA District and State Queen Pageants. I understand that because the persons or organizations authorized to receive the information are not health plans or health care providers, the released information no longer will be protected by Federal Privacy Regulations.

Person/Organization providing information: _____
(Facility Name)

Person/Organization receiving information: The general public through disclosure to the Arkansas Health Care Association, its members and guests, and to local and statewide media, including radio, newspapers, and television.

Purpose of Uses/Disclosures: The above listed facility may disclose the information I have provided so that the AHCA Queen Pageant may be publicized to the general public. Such publications may contain my photograph.

By signing below, I certify that I have read, or had read to me, and understood the following statements:

If I do not sign this form, there will be no effect on my health care or the payment for health care. I may refuse to sign this authorization. I may see and copy the information described on this form if I ask for it, and I can get a copy of this form after I sign it.

This authorization will expire within one year from the date of the Pageant. I understand that I may revoke this authorization at any time by notifying the facility, orally, or in writing, but if I do, the revocation won't have any effect on any actions the facility took before it received the revocation.

Printed Name of Elder: _____

Signature of Elder: _____

Printed Name of Elder's Representative: _____

Signature of Elder's Representative: _____

Relationship of Representative to Elder: _____

Date Signed: _____