

Alumni Consent Form

We want to keep connected with you. Please take a moment to answer the following questions. Your answers will help in planning alumni events and services. Thank you.

ROSECRANCE INC. ALUMNI AUTHORIZATION AND CONSENT FOR DISCLOSURE FOR PURPOSES OF PARTICIPATING IN ALUMNI SERVICES AND SPEAKERS BUREAU

Rosecrance Inc. offers alumni services and activities to support former patients of Rosecrance and their family members ("Alumni"). Under Federal confidentiality and privacy rules (the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Part 160 and 161) - Rosecrance employees and volunteers cannot disclose your personally identifiable health information (including that you or your family member were treated at Rosecrance) to offer you alumni services without your written authorization.

The purpose of this authorization is to permit Rosecrance to contact you for the purpose of participating in these activities after you finish treatment. By initialing the items below, you authorize Rosecrance to use or disclose your Contact Information as described below to provide the following alumni services:

I hereby authorize Rosecrance to disclose my name, address, phone number, email address ("Contact Information") to Rosecrance staff, Rosecrance Alumni Contacts and Alumni Volunteers for the purposes of providing and supporting Rosecrance Alumni Services, being notified of Rosecrance Alumni events and participating in alumni support groups, being notified of area sober events and conferences, and participating in the Rosecrance Alumni Speakers Bureau.

- Receive communications from Rosecrance including but not limited to (please check all that apply)
 - Telephone Calls
 - E-mail
 - Mail
 - Fax
- Provide my name, address, telephone number(s), and email address to Rosecrance Staff and/or Alumni Contacts who will act as a recovery resource for me.
- Identify me as an Alumni Contact, willing to serve as a recovery resource to other alumni, by providing my name, telephone number(s), email address, city and state to newly discharged or other alumni in need of support.
- Allow Rosecrance Staff to contact me regarding my availability to participate in any Rosecrance Speakers Bureau opportunities. The Rosecrance Speakers Bureau offers recovering alumni the opportunity to share their story of recovery and treatment experiences with schools, media and other organizations. When Rosecrance Staff contacts me regarding a specific speaking opportunity, and if I accept that speaking opportunity, I authorize Rosecrance to share my first name and last initial and communication contact information when there is a need for the organization to contact me directly.

The information shall become effective immediately and shall remain in effect until one of the following expiration events:

1. You inform Rosecrance you no longer wish to participate in Rosecrance Alumni Services and/or the Speakers Bureau;
2. You inform Rosecrance you no longer wish to receive Alumni communications from Rosecrance; or
3. You revoke your authorization in writing.

You may revoke your authorization at any time except to the extent that action has been taken in reliance on this authorization prior to revocation. To revoke this consent, you may contact Rosecrance Alumni Services by phone at 815-391-1000 or in writing to the attention of the Privacy Officer, 1601 University Drive, Rockford, IL 61107, or by telephone at 815-391-1000, or by email at privacy@rosecrance.org.

The information disclosed in connection with these alumni services has also been disclosed from records protected by Federal Regulations concerning the Confidentiality of Alcohol and Drug Abuse Records (42 CFR Part 2) and State Law protecting confidentiality of patient records. These laws prohibit making further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

You understand that you must observe these confidentiality restrictions for other alumni participating in these activities. You have the right to inspect or copy your information that is used or disclosed in accordance with this authorization. You have a right to request restrictions on the use or disclosure of your personally identifiable health information. While this authorization is required as a condition to Rosecrance offering you alumni support services, it is not required as a condition of providing you treatment, of accepting payment, or of your eligibility for benefits. You may refuse to sign this authorization, but such refusal will prohibit your participation in future Rosecrance Alumni Services as outlined above. You will be given a copy of this consent for your records.

Alumni name (printed): _____ Date _____

Address: _____

Email address: _____

Alumni signature: _____

I authorize Rosecrance to disclose my information to alumni services as stated above.

**Rosecrance
Health Network**
1021 N. Mulford Road
Rockford, Illinois 61107

T 815.391.1000
F 815.391.5041

rosecrance.org

Please return the completed survey to David Sutor, Alumni Coordinator, 1021 North Mulford Road, Rockford, Illinois 61107-3877.