THE CONRAD | PEARSON CLINIC

AUTHORIZATION TO USE INFORMATION

Patient Name: _____ Date of Birth: _____ Chart Number: _____

I authorize the Conrad Person Clinic ("CPC") to use my information for the purpose of contacting me to inform me about educational seminars, goods or services that CPC believes may be of interest to me as a patient.

Expiration: This Authorization will expire five years from the date it is executed unless otherwise specified in writing.

Revocation of Authorization: I understand that I may revoke this Authorization by submitting a written revocation to CPC and that my revocation shall not be effective with respect to any use made by CPC in reliance on this Authorization prior to the date of receipt of my revocation.

Authorization is not a Condition to Treatment: I understand that CPC cannot require me to sign this Authorization in order to receive treatment unless the treatment is related to my participation in a research program.

Potential Re-Disclosure: I understand that information that has been disclosed has the potential to be further disclosed.

Email: I agree that CPC may contact me via email at the email address on file to inform me about the educational seminars, goods or services that CPC believes may be of interest to me as a patent. I express agree to receive these communications via email.

I have read and understood this Authorization and my questions have been answered. I certify that I am the patient listed above or a person authorized to sign on the patient's behalf.

_____ _____
Patient/Patient Representative Signature Date

_____ _____
Print Name of Person Signing Relationship to Patient