

CLOSING THE **ADDICTION** **TREATMENT GAP**

Story Collection Form

Sharing your personal addiction, treatment, and recovery story is a great way to connect a human face to the need for access to high-quality addiction treatment for all who need it in Rhode Island.

We would love to hear your story, and to share it with others. Please consider including your first name, last initial, and city/town along with your story on the form below. If you prefer to remain anonymous, please provide only your city/town and story. Thank you!

Name (First Name and Last Initial): _____

Address: _____

Home Phone: _____

Cell Phone: _____

E-Mail Address: _____

May We Contact You?	Yes	No				
Best Time to Contact:	8am-10am	11am-1pm	2pm-4pm	5pm-7pm		
I am a:	Female	Male				
I am:	under 18	18-25	25-35	35-50	50-65	over 65
I live in:	Providence/surrounding urban areas		East Bay	West Bay		
	Blackstone Valley	South County		Newport/Middletown		

My Story: _____

** Please fill out the HIPAA Authorization Form on the reverse side. Although this form requires your name, address, and contact information, we will only use your first name, last initial, and city/town with your story. **



Lifespan

Authorization and Release For Photography/Audio and Videotaping/Broadcasting/Interviewing [When Protected Health Information is Involved]

Patient Name (please print): _____

Patient Address (city/state/zip): _____

Patient Date of Birth: _____ Patient Phone #: _____

- As applicable and as further described below, I authorize Lifespan and its affiliates to photograph, video and/or audiotape, and/or interview me, or I agree to take part in any radio or TV programs (the "Permitted Interaction").
Describe nature of Permitted Interaction (i.e. context of interview, event at which photos are to be taken, etc.) and nature of protected health information to be gathered about patient:

Possible media opportunities/ interviews and/or inclusion in marketing collateral, website (excluding blogs) and other related materials about personal experience with addiction

- I authorize the Lifespan Marketing and Communications department to (1) identify me by name in any photographs, videos and/or audio tapes, interviews, broadcasts and/or news stories, generated from the Permitted Interaction, and (2) to use or disclose such materials (along with my name) for display in print, radio, TV or internet media or other form of media for advertising, marketing, promotional and educational purposes (the "Permitted Use"), and (3) to use and disclose such materials as necessary to effectuate the Permitted Use (i.e. to employees of newspapers or radio stations).
- I authorize Lifespan to copyright any photographs, videos and/or audiotapes, interviews, broadcasts and/or news stories, generated from the Permitted Interaction.
- I understand that, to the extent the content of the Permitted Interaction contains my protected health information, this information is protected under the federal privacy laws and regulations and under the General Laws of Rhode Island, and cannot be disclosed without my written consent except as otherwise specifically provided by law.
- I understand that if the person or entity that receives my protected health information (as applicable) is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore I release Lifespan from all liability arising from this disclosure of my health information.
- I understand this authorization will expire ten (10) years from the date signed below. Prior to the expiration date, I understand I may revoke this authorization by notifying, in writing:
**Lifespan Marketing and Communications
Coro Building, Second Floor
167 Point Street
Providence, Rhode Island 02903**
I understand that any previously disclosed information would not be subject to my revocation request.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits at Lifespan.

This form must be fully complete before signing.

Signature of Patient or Patient's Legal Representative

Date

Print Patient's Name

Print Name of Legal Representative (if applicable)
(A copy of this signed form will be provided to the patient).

Relationship to Patient