Mercy Healthcare Foundation
1410 North 4th Street
Clinton, IA 52732

# Jackson Rhys Laurion
# Butterfly Memorial
## Butterflies quantities are limited

I would like to purchase an engraved butterfly(s) which will be placed on the Butterfly Memorial Wall at Mercy Medical Center-Clinton.

**Butterfly includes 2 lines engraved at a cost of $35 per butterfly.**

Letters for engraving on line 1-**Baby's Name**
_____
Letters for engraving on line 2-**Baby's Date**
_____

Name: _____
Address: _____
City: _____
State: _____
Zip: _____
Check: _____
Credit Card: _____

**Make checks payable to:** **Mercy Healthcare Foundation**
**Attention: Theresa Rieger**
**1410 North 4th Street**
**Clinton, IA 52732**

**Thank you for your continuous support!**

Mercy
MEDICAL CENTER
CLINTON
*A member of Mercy Health Network*

**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) FOR MERCY MEDICAL CENTER – CLINTON'S MARKETING AND COMMUNICATIONS PURPOSES**

I authorize the use and disclosure of my name, likeness, biographical information and/or health information as described below.

Patient Name_____ Date of Birth _____

1. Person(s) authorized to use/disclose the information:
   X Mercy Medical Center and Medical Staff Members
   Specify name(s) if known_____

2. Person(s) or types of persons who will receive the information:
   X Patients/Visitors/Public who will see my image or information in a newsletter or other communication

   X News Media

   X Other (specify): Jackson Laurion Memorial Butterfly Wall

3. Description of information that may be used/disclosed:
   X Image (photograph / video / electronic or audio media):
   Date of Image_____
   Description of Image _____

   ☐ Specific Health Information (describe):
   _____

   _____

4. The information will be used or disclosed for the following purposes:
   X Mercy Medical Center's print publication, display, multimedia production, advertisement or on-line publication

   X News media story in a newspaper, magazine, radio, television broadcast or Internet site

   X Other (specify): _____

5. I understand that I may refuse to sign this authorization and that my treatment, payment, enrollment or eligibility for benefits will not be conditional on my signing or refusing to sign this authorization.

6. I understand that I may inspect and/or receive a copy of my photo and/or health/biographical information that was used or disclosed under this authorization.

7. I understand that if the person or entity that receives my information is not a health care provider or a health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

8. I understand that I may revoke this authorization in writing at any time except to the extent that Mercy Medical Center has already used my photo and/or health/biographical information in response to this authorization. Revocation requests should be directed to the address below.

9. I understand that revocation of this authorization will not affect use or disclosure of photos and/or health/biographical information that I provided to representatives of the news media.

10. I understand that this authorization will remain in effect until revoked by me or until it expires under applicable laws.

_____ _____
Signature of Patient or Representative Date

_____
Patient's Name

_____ _____
Name of Personal Representative (if applicable) Relationship to Patient

(A copy of this signed form will be provided to the patient)

For questions contact:

Mercy Healthcare Foundation – Clinton, 1410 North 4th Street, Clinton, Iowa 52732
Theresa Rieger, Administrative Secretary-
Phone (563) 244-3535
Email: riegert@mercyhealth.com