THE CENTER
for Health Improvement
HAYSMED

success stories - member
2500 canterbury dr., hays, ks
www.haysmed.com/the-center

The Center for Health Improvement relies on happy members telling others about their own success story. We both may be able to **make a difference** in someone's life by sharing the positive experience(s) that you have encountered since being a Member of our facility. If you have a story to share we want to hear it. Please stop by the Front Desk at The Center or speak to any fitness staff for more information.

My Success Story

Member Name: _____

How long have you been a member? _____

What was your reason for joining The Center?

_____

_____

What is or was your goal?

_____

_____

_____

Have you accomplished your goal or are you still working towards it? If so, how?

_____

_____

_____

Has there been a particular program/class, etc. that helped you break a barrier?

_____

_____

_____

What is your story?

_____

_____

_____

_____

_____

EXHIBIT A

Name:_____
Print Patient Name Here

HAYS MEDICAL CENTER
AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Check appropriate box:

☐ I hereby authorize Hays Medical Center (including its employees and agents) to disclose protected health information concerning the patient identified above to members of the media for purposes of news reporting. This authorization is limited to such information relating to patient's name, address, phone number and an explanation of patient's specific injury or illness; it is not intended to authorize the release of all protected health information relating to the patient to members of the news media.

☐ I hereby authorize Hays Medical Center, Inc., (including its employees and agents) and members of the media to use, disclose, publish, and/or copyright for Hays Medical Center's educational, publicity, marketing and/or news reporting purposes any and all (a) information obtained in the course of an interview with the patient identified above, and/or (b) video or photographic images of the patient identified above and his/her property, regardless of when such interview was conducted and/or images were created.

This authorization shall remain in effect for five years from the date listed below at which time this authorization shall expire. I understand that Hays Medical Center, Inc. shall not condition treatment upon the execution of this authorization.

I understand the parties to whom I am granting this authorization may use, disclose, publish, and/or copyright such information and/or images with or without the name of the subject and may make changes or alterations to such images. I understand that if the person or entity that receives such information and/or images is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by that person or entity and no longer would be protected by those regulations.

I understand that I can cease any interview, recording, filming, and/or photographing of the patient identified above, and by doing so, I revoke this authorization. I understand that I may otherwise revoke this authorization at any time (except to the extent that action has been taken in reliance upon it) by mailing or hand-delivering written notification to the following person: Privacy Officer, Hays Medical Center, Inc., P.O. Box 8100, Hays, KS 67601.

_____ _____
Date Signature of Patient or *Personal Representative*

_____
Patient's address and telephone number

_____
Printed Name of Personal Representative and Relationship to Patient

_____
Personal Representative's address and telephone number

_____ _____
Date Signature of Witness