Medical and Liability Release/Insurance Information

THIS FORM **MUST** BE COMPLETED AND SIGNED BY THE **LEGALLY RESPONSIBLE CAMPER OR GUARDIAN**.

Easterseals Florida - Camp Challenge carries a limited Camper's Accident and Sickness Insurance Policy covering all campers. Details of this may be obtained by contacting the camp office. Pre-existing conditions are not covered under this policy. All medical expenses not covered under Camp Challenge's Accident and Sickness Policy will be the responsibility of the legal guardian. The following information is required for camp records. Please complete with respect to the hospitalization and/or major medical insurance covering the camper.

Name of Insurance Carrier: ____________________________

Policy Holder: _______________________________________

SSN#:____

Policy Number: ____________________________________

Certificate Number: _________________________________

Code or Group Number: ______________________________

Medicare/Medicaid Number:__________________________

I hereby give permission for ____________________________________(camper name) to receive any examinations and any medical or surgical treatment which the camp's nurse, camp's physician, or any other referred physician, dentist or hospital may determine to be advisable during the camper's period of attendance at Camp Challenge.

This health history is current to the best of my knowledge and belief; and the camper herein described has permission to engage in all prescribed activities, except as noted. Reports and records may be requested from or sent to doctors and referring agencies. This form may be photocopied for use outside of Camp.

I am in receipt of the Easterseals Florida's Notice of Privacy Practices. __________________________

(Please Initial Here)

I release and completely discharge Easterseals Florida, Inc., Camp Challenge, its officers and directors, and any persons in privity with any of them, from any and all liability, legal responsibility, claims, damages, or causes of action arising from any and all damage or injury to my person or property, including my death that may occur while on Easterseals property or being provided services by volunteers or contractors of Easter Seals, and hereby waive all such claims or causes of action. This release, discharge and waiver is intended to apply even to affirmative acts of negligence on the part of the released parties, i.e. Easterseals Florida, Inc. and/or its representatives, agents, employees, officers, directors, volunteers, consultants or contractors.

If I am injured, I agree not to sue Easterseals Florida, Inc., Camp Challenge, or any officers, directors, representatives or agents thereof, or start any other type of legal action as a result of any damage or injury I may incur. In the case of my death, I hereby direct my personal representatives, heirs, executors, next-of-kin, or spouse not to sue these parties on behalf of my survivors or my estate.

____ ________________

Signature of Legal Guardian *Date*

Information on this page will be verified and witnessed by Easterseals staff at check-in.

DON'T FORGET

Include a copy of insurance card (<u>front and back)</u> or Medicare/ Medicaid card with this form.

Authorization to Receive Protected Health Information via Text Message

Client: ____

Last First DOB

Parent/Legal Guardian:____

Last First Relationship to clien

I give permission for Easterseals Florida to send/receive information via text message to my electronic device that may contain protected health information. Protected health information can include the client's name, date of birth, address, diagnosis, treatment plan, medications, photos and any other medical related information. By signing this authorization, I understand that the information will not be encrypted and will not be secure. I also understand that there may be some level of risk that information in an unencrypted text message could be read by someone other than myself. Any information disclosed in accordance with this authorization may be re-disclosed by a recipient and is no longer protected by federal or state health privacy laws.

I understand that this authorization is voluntary and that Easterseals Florida will not condition any treatment or funding to the client on the completion of this authorization. I understand I have the right to revoke this authorization at any time.

Revocation will be provided in writing to Easterseals Florida. Revocation will not apply to any information that has been released following receipt of this authorization and prior to revocation. This authorization is valid until the client is no longer receiving services with Easterseals Florida.

The telephone number(s) that I am authorizing to receive the text messages described above is:

Please initial below:

☐ I will inform Easterseals Florida of changes to my telephone number immediately. I understand that Easterseals Florida is not responsible for any communications sent to my former number, listed above, during the lapse in time from previous number to my new number.

Parent / Legal Guardian: Signature________________________________Date:__________________

Authorization – Use of Disclose Protected Health Information Media and Testimonial Release

Date: ____________________

Client Name: ______________________________________ Birth Date: ________________________

____
Street Address Apt #

____
City State ZIP

We appreciate the fact that you would like to provide information, a testimonial or comment about your experience or care received from us. With your permission and authorization we may use your information in printed materials, on our web site, on social media we create (e.g. Twitter, Facebook, Instagram), and we may release it to the media. We may send text messages e.g. photos internally to other Easterseals Florida staff to obtain approval prior to use. Please understand this may involve the use or disclosure of information protected by federal health privacy law that requires your authorization first. We will use or disclose only information you authorize. We may respond to a comment you post on social media we maintain or thank you for your testimonial. If we respond or thank you we will not use or disclose any information you have not previously authorized. Any narratives, depictions, pictures, film, photographs, audio-visual or sound recordings or testimonials of you made by Easterseals Florida or its respective employees and agents may be used by Easterseals Florida, and those acting with its permission, for the purpose of illustration, broadcast, or testimonial in connection with the work of Easterseals Florida and these materials may be released to the general public. You assign to Easter Seals Florida all of your rights to these materials. This form explains your authorization. Please use it to authorize Easterseals Florida to use or disclose your information. We will give you a copy.

Authorization

I authorize Easterseals Florida to use and disclose information described in Section 1 of this form to publish information, a testimonial or comment about my experience or care I have received. This includes posting my comment on social media maintained by or for Easterseals Florida. My authorization to use my information extends to any persons working on behalf of Easterseals Florida to create or maintain materials in any format that may include my information, testimonial or comment including but not limited to printed materials, web sites and social media. I authorize Easterseals Florida to respond to any comment or testimonial I provide to the extent that its response does not use or disclose any protected health information other than the information described in this authorization.

1. Information to be used or disclosed may include the following:
    - client's photograph
    - client's name (whole or part)
    - client's story or testimonial
    - audio or video recording of client
    - comments written by client or guardian

    If there is something listed above that you do not want disclosed, please write it in the box below.

2. <u>Identification of persons to whom use or disclosure of the information described in Section 1 may be made</u>
   The information described above may be used or disclosed to the general public who may view or read the information on materials created by or for Easterseals Florida including but not limited to photographs, videos, printed materials, web sites and social media.
3. <u>Purpose</u>
   The purpose of this Authorization is to permit Easterseals Florida to use or disclose the information described in Section 1 for public relations and marketing purposes by publication in any medium it creates or is created on its behalf including but not limited to its web site, social media, social media web site, newsletters, printed materials and press releases. Easterseals Florida will not receive any payment or financial remuneration from anyone for use or disclosure of this information. The materials created by Easterseals Florida, its employees and agents are owned by Easterseals Florida. The materials do not need to be submitted to me for further approval.
4. <u>Expiration Date of this Authorization</u>
   This authorization shall be valid - unless I revoke it earlier in writing - for ten (10) years following the date of the authorization.

I understand

1. I may revoke this authorization at any time by giving Easterseals Florida notice of my revocation in writing to Rikesha Blake, Corporate Compliance Officer, 2010 Crosby Way, Winter Park, FL 32792
2. My revocation of this authorization will not apply to information used or disclosed as permitted by this authorization before I give Easterseals Florida written notice of my revocation.
3. Easterseals Florida may not condition my treatment or payment, enrollment or eligibility for benefits on whether I sign this authorization.
4. Information disclosed as permitted by this authorization may be re-disclosed by persons who receive it and is no longer protected by federal health information privacy law.
5. I have a right to request and receive a copy of this authorization.
6. I will not receive any payment or financial remuneration for the information I am authorizing Easterseals Florida to use and disclose by this authorization.

I understand this Authorization to Use or Disclose Protected Health Information for Testimonials and Social Media, signed it voluntarily and received a copy.

Signature, Individual/ Personal Representative ______________________________

Print Name, Individual/Personal Representative ______________________________

Personal Representative's Authority to Act ______________________________

To be completed by Easterseals Florida staff:

☐ Identity of the Individual verified

or

☐ Identity, Authority to Act of Personal Representative verified

Received and confirmed for Easterseals Florida by:

____

Signature | Printed Name and Title