INDIVIDUAL AUTHORIZATION FOR RELEASE OF INFORMATION

Wills Eye understands that information about you and your health is personal and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we may use or disclose your protected health information for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before agreeing to the terms of this authorization.

USE AND DISCLOSURE COVERED BY THIS AUTHORIZATION

Who will use and disclose my information? Wills Eye will disclose the information you submit about your Wills Eye experience by electronically posting it to www.willseye.org and/or Wills Eye social media channels. We will send you messages regarding the status of your submission. Wills Eye may also use the information you submit about your Wills Eye experience for: (i) educational, training, and/or promotional purposes at Wills Eye (ii) publicity, advertising (print, digital, and/or television), publications, and/or solicitation of contributions; and/or (iii) other public display or viewing.

Who will see my information? Anyone visiting www.willseye.org and/or Wills Eye social media channels may see or use the information you submit. In addition, in the event HSS uses your information as described above members of the general public will see the information.

What information will be used or disclosed? The information used and disclosed will be limited to the information you submit through this website.
The information posted/disclosed on www.willseye.org and/or Wills Eye social media channels, or otherwise used and/or disclosed as described above, may include:

- your name
- the city/town, state/province/territory, and country where you live;
- the story of your care at Wills Eye with information on your condition/injury, diagnosis, and treatment (including surgery if applicable);
- the name of your Wills Eye physician(s); and your photo and/or video.

If you submit sensitive information, that information will be deleted from your submission prior to your story being posted to www.willseye.org and/or Wills Eye social media channels, or if the sensitive information cannot be deleted from your submission without compromising the integrity of your story, Wills Eye may decline to post your submission altogether. The following types of information are considered sensitive and will not be posted/disclosed:

- HIV-related information (which is any information indicating that you have had an HIV-related test, or have HIV infection, HIV-related illness or AIDS, or any information that could indication you have been potentially exposed to HIV);
- Substance abuse information;
- Psychiatric/psychotherapy care information;
- Sexually transmitted disease information;
- Tuberculosis information; and
- Genetic information.

What is the purpose of the use or disclosure? The purpose of the use or disclosure is to share your Wills Eye experience.

SPECIFIC UNDERSTANDINGS

By agreeing to the terms of this authorization, you authorize the use or disclosure of your protected health information, as described above. This information may be re-disclosed if the recipient(s) described in this authorization is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations.

You have a right to refuse to agree to the terms of this authorization. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not agree to the terms of this authorization, but we will not be permitted to disclose your information as described on this authorization without your agreement.

You have a right to receive a copy of this authorization after you have agreed to its terms. If you would like a copy of this authorization, please send your request to: Attn: Patient Stories, Wills Eye Hospital, 840 Walnut Street, Philadelphia, PA 19107.

If you agree to the terms of this authorization, you will have the right to revoke it at any time, except to the extent that Wills Eye has already taken action based upon your authorization. To revoke this authorization, please write to Attn: Patient Stories, Wills Eye Hospital, 840 Walnut Street, Philadelphia, PA 19107.

Unless you represent below that you are the personal representative of an adult or minor patient, Wills Eye will only post information about you. If you submit information about another patient or individual that could be considered protected health information, that information will be deleted from your submission prior to your story being posted to www.willseye.org and/or Wills Eye social media channels, or if the information cannot be deleted from your submission without compromising the integrity of your story, HSS may decline to post your submission altogether.