

Advanced Care Rx  
500 N Cass St  
Berrien Springs, MI 49103

Pat. Name (Printed) \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Maid Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Race \_\_\_\_\_ Phone Number \_\_\_\_\_  
Relaymy Care Provider \_\_\_\_\_

**Consent to the Marketing of My Health**

I am John Smith, 45 years old, living at 123 Main St, Berrien Springs, MI 49103. I am giving my consent to the Marketing of My Health.

I understand that the Marketing of My Health is a program that allows my health information to be shared with other health care providers and health plans. I understand that my health information may be used for marketing purposes, including the sale or transfer of my health information to other parties. I understand that I have the right to revoke my consent at any time.

I understand that my consent is not required for the provision of health care services to me. I understand that my consent is not required for the provision of health care services to my family members. I understand that my consent is not required for the provision of health care services to my health plan. I understand that my consent is not required for the provision of health care services to my employer.

**Consent to the Withdrawal**

I understand that I have the right to withdraw my consent to the Marketing of My Health at any time. I understand that my withdrawal of consent will not affect the provision of health care services to me. I understand that my withdrawal of consent will not affect the provision of health care services to my family members. I understand that my withdrawal of consent will not affect the provision of health care services to my health plan. I understand that my withdrawal of consent will not affect the provision of health care services to my employer.

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Signature of John Smith (Printed) \_\_\_\_\_ Date \_\_\_\_\_

Doc. Signature for Provider \_\_\_\_\_ With Date \_\_\_\_\_

Provider	Date	Signature	Witness	Printed Name and Signature of Witness

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