

Patient Story and Likeness Authorization

Permission to use your story, words, picture and voice in Direct Care Alliance marketing

This form asks for your permission to let Advanced Healthcare Alliance DBA Direct Care Alliance ("DCA") share your experience with DCA in its marketing, so other patients and employers can see how DCA coordinates care. Please read every section. You can ask questions before you sign, and you can say no to any part of it.

Signing is completely your choice.

Your care through DCA, payment for your care, your enrollment and your eligibility do not depend in any way on whether you sign this form. You can refuse to sign, sign only the parts you are comfortable with, or cancel it later.

SECTION 1

About you

Patient full legal name

Date of birth

Phone

Email

Mailing address, city, state and ZIP

If someone is signing for the patient

Fill this in only if the patient is under 18 or can't sign for themselves.

Representative full name

Relationship to patient

- ☐ Parent of a minor
- ☐ Court-appointed legal guardian
- ☐ Agent under a medical power of attorney
- ☐ Other legal authority (describe): _____

SECTION 2

What DCA may use

Write your initials next to each item you agree to. Anything you leave blank is not allowed.

	My story, written by DCA from what I tell them. I'll be given the final version to read before it's used.
	Direct quotes from me, written or spoken.
	Photographs of me.
	Video or audio recordings of me, including clips I give to DCA.
	My first name only.
	My full name.
	Limited health information about my care, as described below.
	The name of my employer.
	The names of the hospital, facility or doctors who treated me.

Health information covered. Only what's written here may be shared. For example: "Breast cancer treatment in 2026, coordinated by DCA, now cancer free."

Health information I allow DCA to share

Specific materials covered. Name any particular photo, video or written piece this form covers. For example: "The video of me ringing the bell."

Specific photos, videos or writing

Never shared under this form: my medical records, test results, record or account numbers, insurance or ID numbers, Social Security number, or home address.

SECTION 3

Where it may appear

Check every place you agree to.

- ☐ DCA's website
- ☐ DCA's social media accounts, including LinkedIn, X, Facebook, Instagram and YouTube
- ☐ Social media posts by DCA's leaders when they share DCA's content
- ☐ Presentations, case studies, brochures and emails to employers, benefits brokers and healthcare partners
- ☐ Conferences, speaking events and news media
- ☐ Paid advertising

SECTION 4

Who shares it, and why

Who may use and share it: DCA, its employees, and the outside contractors who produce DCA's marketing under DCA's direction. Once something is published, it is publicly available.

Why: to show employers, benefits brokers, patients and healthcare partners how DCA coordinates care and what that care is like for a patient.

SECTION 5

How long this lasts

This authorization ends on the date you write below. If you leave it blank, it ends three years after the date you sign.

End date (optional)

SECTION 6

Reviewing before anything is published

- ☐ I want to see and approve the final version of anything that uses my story, words, picture or voice before it's published.
- ☐ I don't need to see it before it's published.

DCA may shorten or lightly edit your words to fit a post or a page, but won't change what they mean.

SECTION 7

Important things to know

- Once your story is published, it can be seen, reposted with comments and shared by others. Information shared publicly under this form may no longer be protected by federal health privacy law (HIPAA).
- Photos, videos and writing that DCA creates belong to DCA. Anything you made yourself stays yours, and you give DCA permission to use it as this form describes.
- You agree not to bring a claim against DCA or its contractors for invasion of privacy, use of your name or likeness, or defamation, for any use that follows this form.
- You'll receive a copy of this signed form.

SECTION 8

Changing your mind

You can cancel this authorization at any time by telling DCA in writing, by email, to the contact below. When DCA receives it:

- DCA stops creating anything new with your story, words, picture or voice.
- Within 30 days, DCA removes it from its website and the social media accounts it controls, and stops using it in presentations and print going forward.
- Cancelling can't pull back materials already printed or handed out, or posts other people have already shared or reposted. It also doesn't affect anything DCA did while this form was in effect.

Send cancellation requests to:

Dawn Thompson, CEO: dthompson@directcarealliance.com

SECTION 9

Signature

By signing, I confirm that I've read this form, my questions were answered, I'm signing freely, and I'm the patient named above or legally authorized to sign for them.

Patient signature

Date

Patient printed name

Representative signature, if signing for the patient

Date

DCA staff member who explained this form

Date

FOR DCA USE ONLY

Keep the signed original in DCA's records. Use only DCA's internal case reference below, never patient details.

Internal case reference

Copy given to patient on

Authorization ends on

Cancellation received on