MAYO CLINIC

Authorization for Media Release – Photograph, Video, or Interview

Story Name	Publication Date *(Month DD, YYYY)*
CNN story on Alyssa Gilderhus	N/A
Physician Name	**Public Affairs Staff**
N/A	Ginger Plumbo / Kelley Luckstein

I authorize Mayo clinic to disclose the name and contact information of:

Patient: Alyssa Gilderhus Birth Date [redacted]

And to disclose details of the following medical conditions any and all aspects of Alyssa's history with and care from Mayo Clinic.

I authorize Mayo Clinic personnel, including the Patient's treating physician, to be interviewed by **CNN and/or an authorized agent, representative or employee thereof** and to discuss details of the Patient's medical conditions, without limitation. I do not authorize any party to disseminate, publish or otherwise publicly disclose any information protected by HIPAA. This authorization does not extend to any third party other than the individuals designated by CNN, nor does it authorize Mayo Clinic or any agent thereof to make any public statement, publication, report or disclosure of any kind regarding my medical conditions or the care and treatment rendered to me at Mayo Clinic to any third party whatsoever. Mayo Clinic will not condition treatment on whether Patient signs the authorization.

I understand that this authorization may be revoked at any time except to the extent action has been taken in reliance upon it. Furthermore, I understand that this authorization will remain in effect unless specifically revoked by me. This authorization will not expire unless revoked by Patient in writing as indicated herein. Revocation must be made in writing to Mayo Clinic, Department of Public Affairs, 200 First Street SW, Rochester, MN 55905.

Furthermore, I understand that information used and disclosed pursuant to this authorization may be subject to re-disclosure by CNN and may no longer be protected by federal law.

I understand that a copy of this authorization will be provided to me when Mayo Clinic receives the authorization.

Signature	Date of Signature *(Month DD, YYYY)*		
Alyssa Gilderhus	3-19-18		
Relationship to Patient *(if not patient)*	**Daytime Phone**		
Self	[redacted]		
Mailing Address [redacted]	**City** Sherburn	**State** MN	**ZIP Code** 56171
Email [redacted]			