

RESTRICTIONS ON USE OR DISCLOSURE

I understand that I have the right to request changes or restrictions on certain uses or disclosures of my personal information. I understand that I may change this at any time and that changes must be in writing. Check (√) all that apply.

- () I **do** request communications by alternative means or locations.
How: _____ Where: _____
- () I **do** authorize disclosure of my personal information to family members, relatives or others.
Who: _____ Relationship: _____
- () I **do not** authorize LifeShare to contact me for marketing or fundraising purposes.

Signature: _____ Date: _____

Printed Name: _____

SSN: _____ / _____ / _____ Date of Birth: _____

mail or deliver to:

Privacy Officer
LifeShare Blood Centers
8910 Linwood Avenue
Shreveport, LA 71106