

Yes, I/We wish to participate in the  
McLeod Bundles of Joy Baby Wall.

Enclosed is my/our gift of \$250.

Please complete as you wish information  
to appear on tile and ornament:

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
Child's Date of Birth

- Enclosed is a photocopy of my child's footprint.
- I give permission to access my child's medical records to obtain a copy of his/her footprint. (signature required on reverse side of this form)
- Tile purchased is in memory of the child.

Your Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Email: \_\_\_\_\_

Payment: Check Credit Card Payroll Deduct  
Circle One: Visa \* Master Card \* American Exp. \* Discover

\_\_\_\_\_  
Name that appears on card.

Card #: \_\_\_\_\_

Exp. Date: \_\_\_\_\_ Security Code: \_\_\_\_\_

# Bundles of Joy



## CONTACT US

843-777-2694



## VISIT US

300 S. Dargan St.  
Florence, SC



# Bundles of Joy

Baby Wall of Footprints

McLeodFoundation.org

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# Bundles of Joy

## Baby Wall of Footprints



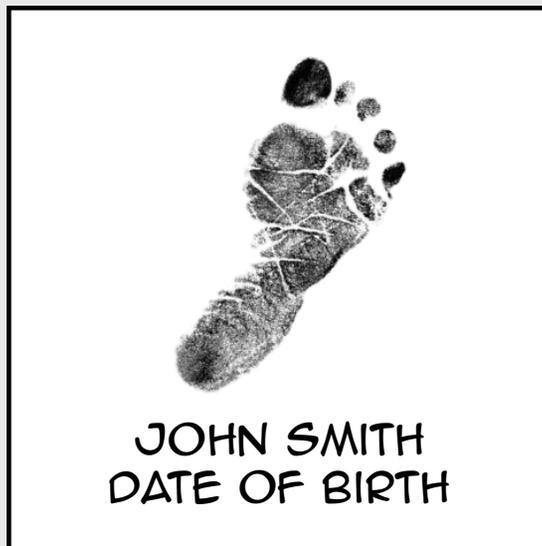
The birth of a baby can be a wonderful, life-changing experience for families. You can honor or celebrate a new life through the McLeod Bundles of Joy Baby Wall.

This special wall is a collage of colorful tiles with your child's footprint, name and date of birth engraved on it. The wall is located in the waiting area of Labor and Delivery. The tiles can be purchased through the McLeod Foundation for \$250 a tile.

Included with the purchase of your tile is a keepsake glass ornament with your child's footprint, name and date of birth that will be sent to you at the address you provided.

On your child's second birthday, the tile will be removed and mailed to you at the address you provided.

For additional information, call the McLeod Foundation at (843) 777-2694.



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## Authorization for the use or disclosure of Protected Health Information (PHI)

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient # or MR# (optional): \_\_\_\_\_

I authorize McLeod Health Medical Records (provider) to use or disclose my "protected health information" (PHI) to: McLeod Health Foundation, 300 S. Dargan St., Florence, SC

Photo copies of the child's footprints

Purpose: McLeod Bundles of Joy Baby Wall Tile and Ornament

A.) I understand that PHI may include medical records disclosed by health care providers and facilities that previously provided treatment to me.

B.) I understand the PHI may include information and records protected under Federal Law (such as alcohol and drug abuse treatment) and/or State Law (such as mental health, AIDS or HIV).

C.) I understand I may revoke this Authorization at any time however the revocation will apply to PHI that has already been used or disclosed pursuant to this authorization. Contact the Privacy Official to initiate the revocation procedure.

D.) I understand that McLeod Health will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

E.) I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal privacy standards.

F.) I understand that this Authorization will expire in 90 days after it is signed unless date is specified here \_\_\_\_\_

I have read and understand this Authorization. I certify that I am the Patient listed above or the person authorized to permit release of records on the Patient's behalf. I hereby release Provider (as named above) from liability or damages arising in connection or related to with the use and/or disclosure of my protected health information pursuant to this Authorization.

\_\_\_\_\_  
Authorized Representative Name Relationship

\_\_\_\_\_  
Telephone # Date

\_\_\_\_\_  
Signature (required to process)