



**Decatur County
Memorial Hospital**
The Quality Care You Want. Close By.

MARKETING: Empowered Community Form

To be completed by community member or patient:

Name: _____

Date of Birth: _____

Phone Number: _____

Mailing Address: _____

City/State/Zip: _____

Email: _____

Would you like to receive information from Empowered Community and Decatur County Memorial Hospital regarding upcoming events, educational opportunities, and support services? Yes No

Community Member / Patient Signature:

(The above signed certifies that they have read the following and accepts its terms.)

CONSENT FOR USE OF CONTACT INFORMATION

I understand this Organization is committed to safeguarding my personal contact information. My contact information will be used solely for the purpose of providing relevant updates related to upcoming events, educational opportunities, and support services.

I understand I may opt out of these communications at any time by contacting dcmh.marketing@dcmh.net

Submit this form to dcmh.marketing@dcmh.net