Ochsner
Golden Opportunity

Golden Opportunity Membership Application

Golden Opportunity, Celebrating 26 Years of Healthy Lifestyles

I am enclosing the membership fee: ( ) New Member: $30 ( ) Spouse/Partner: $25*

**Cost to join is $50 for a member and spouse/partner.*

Applicant Information: ( ) Mr. ( ) Mrs. ( ) Ms.

_____

First Name Middle Name Last Name Nick Name

Street Address: _____

City: _____ State: _____ Zip Code: _____

Cell Number: _(_____)_____ Home Number: _(_____)_____

E-Mail Address: _____

Date of Birth: _____

Are you a Veteran of the Armed Forces (Circle One): Yes or No Branch of Service: _____

Preferred Contact Method (Circle One): Text Email U.S. Postal Service

In Case of an Emergency:

Name: _____ Relationship:_____

Phone Number: (_____)_____ Cell or Home? (Circle one)

Referral Information:

How did you hear about Golden Opportunity? _____

If you were referred, please tell us by whom? _____

I would like to refer: _____

Cell Number: _(_____)_____ Home Number: _(_____)_____

Please complete the HIPAA authorization form on the back of this page accepting or declining the use of photos and videos being used for internal/external marketing activities.

Return completed application and fee (check payable to Golden Opportunity)
Golden Opportunity
15330 Randi Ct.
Prairieville, LA 70769

Call (225) 236-5496 or email goldenopportunity@ochsner.org for additional information.
OHS may discontinue membership benefits at any time.

Revised 03/27/26

For Office Use Only

Join Date: _____ SF Entry Date: _____
Primary Applicant Chargent Number: _____ Check #: _____ CC_____ Cash_____
HIPAA: _____Yes _____No _____Declined New Member Packet Mailed: _____

Authorization to Use and Disclose Protected Health Information

Golden Opportunity
Project Title

/ /2026

Name of Patient / Participant | **Date**

Street Address | **Email**

City, State, Zip | **Phone Number**

Are you vaccinated against COVID-19?
Yes _____ No _____

☐ **DO NOT USE MY PHOTO**

Check off items being released to Ochsner Health System for the purpose of public relations, business development, sales, and internal and external marketing activities:

☐ Discharge Summary	**X Photographs/Video**	☐ X-ray Report
☐ History & Physical	☐ Clinic Visit	☐ ER Record
☐ Consultation Reports	☐ Hospital Admission	☐ Entire Record
☐ Pathology Reports	☐ Abstract _____	☐ Other_____
☐ Laboratory	☐ Dictated Letter	
☐ Cardiology	☐ Operative Report	

The undersigned hereby authorizes or ratifies, in addition to the release of the above information, using quotes and testimonials, the taking and use of photographs, film, audiotape and/or videotape during treatment or other procedures including special events hosted by Ochsner heath System and its subsidiaries and affiliates for use by these institutions for the purpose of public relations, business development, sales, and internal and external marketing activities, including use by or for news media, and further authorizes the use of the undersigned's name with said photos, film, print or tape in advertising activities, television commercials or broadcasts, radio ads or broadcasts, onsite vehicles (plasma screens, kiosks, etc.), print ads, annual reports, brochures, websites, online outlets, outside billboards, business communications, books, scientific or industry papers, internal communications, e-newsletters, email marketing, social media platforms or outlets (including but not limited to mobile/smart phones, Facebook, Twitter, YouTube, Flicker, etc., and/or any digital technologies, including those not known today.)

In authorizing the release of the confidential information identified above, I hereby waive all restrictions or privileges imposed by law and release Ochsner Health System and its staff from any restriction or privilege in connection with the disclosure or release of professional record, observation, or communication. I do understand that the information that is being released may be subject to re-disclosure by the recipient and may no longer be protected. I understand that my treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization.

This authorization may be revoked in writing at any time, except to the extent that Ochsner Health System has already taken action in reliance on it. Letters to revoke this authorization should be addressed to Ochsner health System, Release of information Department, 1514 Jefferson Highway, New Orleans, LA, 70121.

If not previously revoked in writing, this authorization will expire three years from the date listed on this document.

If expiration date is left blank, authorization will expire within three years.

/ /2026

Print of Participant or Authorized Representative | ***Date Signed***

/ /2026

Signature of Participant or Authorized Represetnative | ***Date Signed***

Relationship to Participant

/ /2026

Witness Signature | ***Date Signed***