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Mary Rutan HOSPITAL
205 Palmer Avenue • Bellefontaine, Ohio 43311-2298
Phone: 937-592-4015

AUTHORIZATION FORM FOR USES AND DISCLOSURES OF PATIENT INFORMATION

Patient Name:	DOB:	Soc. Sec. #:	
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	

I hereby authorize the **use and/or disclosure** of personal health information about the above-named patient, as described below.

1. The information that is the subject of this authorization and which will be used and/or disclosed as set forth below is as follows (check as applicable):

   ☐ Complete Medical Record (excluding billing and pmt. info)

   ☐ Minimum Document Set (check to include):
   - ___ Discharge summary
   - ___ Facesheet
   - ___ History and Physical
   - ___ Operative Reports
   - ___ Emergency Dept. Reports
   - ___ Test Results (labs, radiology, EKGs, EEGs, Echo)

   ☐ Billing and Payment Information

   ☒ Other components (specify): Information regarding sports-related injuries and/or other health issues that may affect athletic participation.

2. Authorization relates to services provided at the following location(s), which collectively constitute the Mary Rutan Organized Healthcare Arrangement (check as applicable):

   _X_ Mary Rutan Hospital

   Mary Rutan Hospital Clinics:
   - ___ Mary Rutan Hospital General Surgery
   - ___ Mary Rutan Hospital Ear, Nose & Throat
   - ___ Mary Rutan Hospital Internal Medicine
   - ___ Mary Rutan Hospital OB/Gyn
   - ___ Mary Rutan Hospital Orthopedics
   - ___ Mary Rutan Hospital Pediatrics
   - ___ Mary Rutan Hospital Urology

3. Complete the following as applicable:

   The Mary Rutan Organized Healthcare Arrangement may disclose and release the patient's personal health information which is described above to the following person(s)/organization(s):

   Any official member of Indian Lake Schools coaching staff involved in the the above-named patient/student athlete's sports-related healthcare decision making and athletic participation given health issues.

   The following person(s)/organization(s) may use the patient's personal health information which is described above:

   Same as above, for the purpose of assisting in the above-named patient/student athlete's healthcare decision making and evaluation of athletic participation given health issues.

4. The purpose of the authorized use and/or disclosure of the information described above is as follows:

   At the request of the patient or representative (check if applicable) _____X_____; OR

   Other (describe)___For the purposes set forth above_____

   _____

5. If you are signing this Authorization as the representative of a patient, describe the source and scope of your authority to act on the patient's behalf:

   _____

   _____

6. I understand that if the person or entity that receives the above information is a not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

7. As described in the Notice of Privacy Practices of the Mary Rutan Organized Healthcare Arrangement, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Mary Rutan Organized Healthcare Arrangement in reliance on this authorization, by sending a written revocation to the Director of Medical Records, Mary Rutan Hospital, 205 Palmer Ave., Bellefontaine, OH 43311.

8. I understand that the Mary Rutan Organized Healthcare Arrangement will not condition the provision of treatment to me or the payment of my claim on the signing of this authorization, except that the Mary Rutan Organized Healthcare Arrangement may condition the provision of research-related treatment to me on the signing of this authorization for the use or disclosure of the patient's personal health information for such research. The Mary Rutan Organized Healthcare Arrangement may also condition the provision of health care to me that is solely for the purpose of creating protected health information for disclosure to a third party on the signing of this authorization. I understand that information will not be released to the above-indicated recipient without my signature.

9. I understand that the information in the patient's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

10. This authorization will expire as specifically set forth in this section; provided that, regardless of the date set forth in this Section 10, this Authorization will automatically expire on the first anniversary of the date signed below:

    Insert applicable date or specific event: _____; OR

    End of research study (applicable only if the authorization is for a research study or for creation and maintenance of a research database or research repository) _____.

This Authorization and request is fully understood and is made voluntarily on the part of the undersigned. The undersigned hereby releases the Mary Rutan Organized Healthcare Arrangement, and each component thereof, of and from any legal liability that may arise from the use, disclosure or release of personal health information in accordance with this Authorization.

_____ Date:_____

Signature of Patient or Representative

_____

Print Name of Patient or Representative

Provide a copy of this signed form to the Patient or the Representative

Hospital Use Only:

MR #:	Acct. #:	Status/Loc:

Prepared by:_____ Date:_____ Released by:_____ Date: _____

Fee: $_____