(Optional) Authorization to Use or Disclose Protected Health Information to Family, Spouse, or Personal

_____

Patient last name (please print) First name Middle name

_____

Date of birth (Month/Day/Year) Cedarville University ID number

As a courtesy to you, University Medical Services (UMS) has provided this authorization form so in the event that you become ill or need assistance with your health care decisions your permission may be given ahead of time to discuss your health care with the person you designate, such as your spouse, family or personal representatives.

As required by the HIPAA privacy rule, UMS may not use or disclose your protected health information except as provided in the UMS Notice of Privacy Practices without your authorization. UMS can only release your protected health information to the person(s) you designate. Effective dates for this authorization are from now until your withdraw your authorization.

I understand I have the right to:

- Revoke this authorization by sending written notice to UMS and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
- Know of any remuneration involved due to any marketing activity as allowed by this authorization and as a result of this authorization.
- Refuse to sign this authorization.
- Receive a copy of this authorization
- Restrict what is disclosed with this authorization.

I hereby authorize UMS and any of its employees to use or disclose my patient health information to the following person(s):

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

Patient health information authorized to be disclosed: PLEASE INITIAL APPLICABLE STATEMENT.

_____ Standard: Any and all health information for the purpose of involvement in my healthcare
(please initial)

_____ Exception(s): _____
(please initial)

I understand that once the information is disclosed to the person(s) listed above, it may be re-disclosed to additional parties and is no longer protected for reasons beyond the control of UMS. I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits whether or not I provide authorization to use of disclose protect patient health information.

_____

Signature of patient or patient's authorized representative Date

_____

Signature of parent or guardian IF PATIENT IS UNDER AGE 18 Date