Authorization for Normal Use or Disclosure of Health Information to RHIO

I, _____ (Name), _____ (Patient residential address), _____ (phone number), _____ (date of birth)

Authorize _____ (Organization Name) to release:

□ my health information

□ health information for my child, _____ (Name), _____ (date of birth)

Type of information to be shared:

___Normal:

- Care management – reports and data that might need to be accessed by a wide range of administrative staff to manage the my access to health services
- Clinical management - less sensitive reports and data, that might need to be accessed by a wider range of personnel not all of whom are actively caring for the patient (e.g. radiology staff)
- Clinical care - default for normal clinical care access (i.e. most clinical staff directly caring for the patient should be able to access nearly all of the EHR)

___VIP / Privileged care

- Access restricted to a small group of people caring intimately for the patient, perhaps an immediate care team or senior clinical party
- The patient must be aware that restricted information sharing may affect quality of care or diagnosis. If the patient has exceptional safety or privacy concerns they are advised to choose this restricted model and inform the Chief Privacy Officer of their primary care organization of their specifics.

I understand that I may identify a visit as containing Personal care which I may request that my provider not publish to the RHIO. In such circumstances, I will specifically authorize the provider to WITHOLD that record to the extent permissible by law, and I will grant specific disclosure permissions for those records.

It is my understanding that the information to be used or disclosed may be used for the following purposes:

- At the request of the individual (no purpose need be specified)
- Insurance Eligibility/Benefits
- Change of Provider
- Additional Medical Care
- Legal Investigation or Action

I understand that if the authorized recipient is not a provider, health plan, or clearinghouse required to comply with federal privacy standards, the information disclosed pursuant ot o this authorization may no longer be protected by the federal privacy standards. However, other state

or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-realted information, and psychiatric/mental health information. In the event that any of the information to be released relates to diagnosis or treatment of mental illness or drug or alcohol abuse and/or confidential HIV-related information, I understand that state and federal law prohibits further disclosure of it without specific written consent of the person to whom it pertains or as otherwise permitted by state and federal law. Information will NOT be given to vendors, or solicitors without express authorization. I understand that a number of laws require reporting or disclosure. These laws are primarily laws which have been enacted to protect the public good. Reporting does not make the information public information. The information may only be used for the stated purpose, like communicable disease, elder abuse, and related regulations. I understand that consent to release or share treatment information between organizations/providers is assumed in continuity of care situations and in emergency treatment situations.

Individual's Rights Relating to this Authorization

I understand that I must be provided with a copy of this form if I choose to sign it. I understand that I am under no obligation to sign this form.

Expiration Date: This authorization is valid until _____ (date). I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

_____ _____

(Individual's Signature) (Responsible Party if applicable)

_____ _____

(Printed Name) (Responsible Party Printed Name if applicable)

_____ _____

Date (Representative Relationship if applicable)