HIPPAA Emergency Medical Authorization
Cedarville University
Civil Rights Bus Tour

Name _____ **ID #** _____

Term	____ Fall ___ Spring ___ Summer	Year	____ 2019 ____ 2020 ____ 2021

Program/Location _____ **Program Dates** _____

Home address (as on insurance card): _____

City:_____ State:_____Postal code: _____

Date of birth (month, day, year): _____

I hereby authorize any healthcare provider or care giver and any of its employees or representatives to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office to Cedarville University staff or representatives and:

1. Parent/Guardian Name: _____

Parent/Guardian Address: _____

City:_____State:_____Postal code: _____

Parent/Guardian Phone: _____

2. Parent/Guardian Name: _____

Parent/Guardian Address: _____

City:_____State:_____Postal code: _____

Parent/Guardian Phone: _____

In case of emergency, whom else could we contact other than the parent(s)/guardian listed above?

Name: _____

Relationship:_____

Address: _____

City:_____State:_____Postal code: _____

Phone: _____

List medical conditions for which you are under a physician's supervision: _____

_____

_____

List any recent surgeries or visits to the emergency room along with the date: _____

_____

_____

List any medications or vitamins you take on a regular basis. Include the name, frequency, and dosage:

_____

_____

_____

_____

_____

List any known allergies along with the reaction and treatment:_____

_____

_____

While Cedarville University will use reasonable good faith efforts to ensure record privacy, I understand that the Patient Health Information authorized to be disclosed: Any and all information with respect to any illness, medical history, immunizations, consultation, prescription, treatment, and copies of all hospital or medical records for the specific purpose of involvement in my medical care, may be re-disclosed to additional parties and no longer protected for reasons beyond our control. I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.

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 or disclose protected patient health information. A photo copy of this authorization shall be considered as effective and valid as the original.*

Printed name: _____

Signature:_____

Date: _____