AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

1. I hereby authorize Genesis HealthCare System to use or disclose the protected health information about me as described below.

Patient's Name (Print) _____ Date of Birth _____

Address _____ Telephone Number _____

2. Approximate Date(s) of Treatment(s): _____

3. Description of the information that may be used or disclosed:

- ☐ Admission & Discharge Dates
- ☐ Aftercare Plan
- ☐ Cardiac Cath. Reports
- ☐ Discharge Summary
- ☐ Drug Use History
- ☐ EKG Reports
- ☐ Emergency Room Record
- ☐ History & Physical
- ☐ Lab Tests*
- ☐ Nurses Notes
- ☐ Operative Report
- ☐ Pathology Report
- ☐ Photographs, videotapes, digital or other images
- ☐ Physician Notes
- ☐ Social History
- ☐ Social Service Notes
- ☐ X-ray Reports
- ☐ Other (Please Specify) _____

(*Lab test does not include results for HIV antibodies unless listed below)
(*Lab test does not include drug/alcohol results unless listed below.)

I authorize use or disclosure of (*check the box and initial below*):

- ☐ _____ Information pertaining to my Drug and Alcohol Treatment.
- ☐ _____ Information as indicated above which may describe or reveal information pertaining to my treatment for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC).
- ☐ _____ Lab test results for HIV antibodies.
- ☐ _____ Lab test results for Alcohol/Drug screens.

NOTICE REGARDING DRUG/ALCOHOL
This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR, Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

4. Genesis HealthCare System may release my protected health information which is described above to the following person(s) or group of persons:

Attorney Kevin F. Kurgis
Person(s), Group of Persons, or Company

100 S. 4th Street, Ste 300
Address

_____
Name of Individual(s)

(614) 464-1610
Telephone Number

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

- ☐ At the request of the patient.
- ☑ Other (describe): personal injury claim

If the authorization is to permit the use or disclosure of the patient's information for marketing, indicate whether Genesis HealthCare System will receive any remuneration or payment from a third party as a result of the marketing: _____

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 Genesis HealthCare System, I understand that I may revoke the authorization in writing at any time, except to the extent that action has been taken by Genesis HealthCare System in reliance on this authorization, by sending a written revocation to Genesis HealthCare System / Health Information Management Department / 800 Forest Avenue / Zanesville, Ohio 43701.

8. I understand that I am not required to sign this authorization form and that Genesis HealthCare System will not condition the provision of treatment or payment to me on the signing of this authorization, except that Genesis HealthCare System may condition the provision of research-related treatment to me on the signing of this authorization for the use or disclosure of my protected health information for such research. Genesis HealthCare System 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.

9. This authorization will expire when case settles.
Insert Applicable Date or Specific Event

_____ _____
Signature of Patient or Patient's Personal Representative — Date

_____ _____
Printed Name of Personal Representative, if applicable — Relationship of Personal Representative to Patient

_____ _____
Signature of Genesis HealthCare System Representative — Date

☐ **ID Check (Employees Must Check ID)**