COMMUNITY REGISTRY DISCLOSURE AND AUTHORIZATION

Patient Information	
Name: _____	Phone Number: _____
Address: _____	E-mail Address: _____
_____	Date of Birth: _____

Gary S. Ruoff, D.O. (Provider) participates in a Community Registry operated by Northern Physicians Organization, Inc. (NPO). This Registry is a tool that we and others involved in your care can use to carry out your treatment and engage in activities to help manage your care such as coordinating your care, conducting quality assessment and improvement activities, and related planning and management activities that do not include treatment (*i.e.*, health care operations).

☐ I opt-out of the NPO Community Registry.

- OR -

☐ I understand that by signing this form, I agree to allow the providers involved in my health care to talk to each other about my care, electronically share my health information with each other to give me better care, and to use my information in health care operations. The software system used by NPO meets the privacy and security standards of both the Health Insurance Portability and Accountability Act (HIPAA) and Michigan law.

WHAT MAY BE DISCLOSED: I authorize my Provider to disclose all of my health information, including demographic information, allergies, medications, immunizations, lab reports, problems and diagnosis, mental health conditions, birth control and abortion (family planning), alcohol or drug use problems, my care plan, health care providers, sexually transmitted diseases (STDs), HIV/AIDS, and genetic diseases or test results. This includes information created before and after the date of this Authorization.

WHO MAY RECEIVE THE INFORMATION:

(1) I authorize my Provider to disclose my health information to NPO and its participating physicians and physician groups that have entered into a written agreement with NPO, before or after the date of this Authorization; and

(2) I authorize NPO to disclose my health information to **(a)** its participating physicians and physician groups that have entered into a written agreement with NPO, before or after the date of this Authorization; and **(b)** other health care service providers (*e.g.*, labs and hospitals) that have entered into a written agreement with NPO, where they have agreed to comply with HIPAA and Michigan privacy laws.

PURPOSES: I allow disclosure of my health care information for medical treatment, to coordinate care among my providers, and to improve my provider's health care operations.

EXPIRATION: This consent will expire, **(i)** upon my death, **(ii)** when my Provider ceases its relationship with NPO, or **(iii)** NPO ceases operation of the Community Registry, whichever is sooner.

REVOCATION: I can revoke my permission at any time by giving written notice to my provider except to the extent the disclosures I agreed to have already been acted on.

ADDITIONAL RIGHTS: I understand that I have additional rights under HIPAA, including the right to request restrictions on certain uses and disclosures of my health information, the right to inspect and copy my health information, and the right to request amendments to my health information, and that these rights are further explained in my Provider's Notice of Privacy Practices.

_____ _____
Signature of Patient Date

_____ _____ _____
Signature of Parent/Guardian or Personal Representative Date Authority to Act