

## **Authorization for Use and Disclosure of Protected Health Information for Communications and Fundraising Opportunities**

**Patient's Name:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City/State/Zip:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Birth Date:** \_\_\_\_\_

**E-mail :** \_\_\_\_\_

I authorize Midwest Orthopaedics to use and disclose to Rush University Medical Center (RUMC) the name of my physician and the name of the department in which I was treated. Information regarding my medical condition, diagnosis or treatment will not be disclosed.

I understand that this authorization will permit RUMC to provide me with relevant information on health care issues and programs through newsletters, publications, and other materials. In addition, I understand I may be contacted about opportunities to provide charitable support to RUMC in the areas pertaining to my personal health concerns.

The above-named practice and RUMC fully support the protection of health information. My name will not appear on any patient list that will be loaned or sold by the above-named practice, RUMC or RUMC's medical practices nor will my name be used for telemarketing purposes.

My authorization is voluntary. My failure to sign this authorization will not affect my treatment, payment or eligibility for benefits in any way.

This authorization is valid until revoked. I may revoke this authorization at any time by submitting a request in writing to Rush University Medical Center, Philanthropy Office, 1700 W. Van Buren, Chicago, IL 60612. The revocation will be effective except to the extent that RUMC has already relied on my authorization.

**Signature** (*patient or authorized representative*)

**Date**

**For office use only:**

Physician/Practice \_\_\_\_\_

EPIC MR# \_\_\_\_\_