

**Authorization to Use and Disclose Protected Health Information
for a Professional Report or Presentation**

We are asking you to let us use and disclose information about your medical condition and treatment for a professional report and presentation.

You received treatment at MetroHealth for a neurological condition that arose subsequent to Covid-19. Dr. Christina Oleson MD and other physicians in the Department of Physical Medicine and Rehabilitation involved in your care would like to submit information about your diagnosis, treatment and follow up to a professional publication. This is for a study of patients with spinal disorders that appear related to Covid-19 and that same information would be used in a related presentation. The purpose is to inform and teach other healthcare professionals. The report and presentation are published in print and on the Internet to journal subscribers with electronic access.

What information is included in the professional report and presentation?

Imaging in the form of MRI may be a part of the presentation but would not be labeled with your information. The professional report and/or presentation will describe your condition and discuss your health and treatment, which may include prior health history, present complaints, and lab tests. You will receive no payment for being in the professional report or presentation.

We will not use your name in our professional report. The report will know your name because they require us to disclose the person whose information will appear in a professional report. In addition, MetroHealth's Institutional Review Board maintains all records confidential. They must keep your name and all information that are tightly secured.

How is the privacy of my health information protected? Federal and state law require MetroHealth workforce members to keep health information confidential. After MetroHealth discloses your information, it is no longer protected by Ohio law. However, the American Spinal Injury Association has strict safeguards that protect privacy and record protection.

Must I agree to participate?

No. You do not have to agree to let us use your information. Your decision will not affect your being able to get healthcare at MetroHealth. It will not affect your enrollment in any health plan or benefits you can receive.

When does this Authorization expire?

This Authorization expires two (2) years from the date of your signature.

Do I have the right to revoke this Authorization? Yes. You may revoke this Authorization by writing to the address below. Your revocation will not affect disclosures made before we receive your letter. This means that if something with your photograph or health information has been presented or published before we receive your revocation, we cannot pull back the presentation or publication.

The MetroHealth System
Privacy Officer
2500 MetroHealth Drive
Cleveland, OH 44109

By signing this Authorization, you allow MetroHealth and your healthcare providers to use or disclose your health information as described above. You have the right to receive a copy of this Authorization.

Patient or Patient Representative's* Signature: _____

Patient or Patient Representative's* Printed Name: _____

Date: 4/22/2023 *Representative _____

*Please provide legal paperwork verifying you are the patient's personal representative (such as a court-appointed guardian or durable power of attorney for healthcare).