ASSIGNMENT AGREEMENT

FOR VALUE RECEIVED, ______________________________ and spouse ______________________________ (individually and together referred to "Assignor"), unconditionally and absolutely assigns, transfers, sets over and conveys to Russell Township through its Board of Trustees ("Assignee") all of Assignor's right, title, and interest in and to—whether now or hereafter existing and of every kind and character—the bill for health care services dated ____________________ from ______________________________ ("Creditor") to Assignor (the "Bill"), a copy of which is attached to this Assignment Agreement and incorporated herein as **Exhibit "A.**"

Assignor authorizes Assignee to make Bill payments directly to Creditor, and Assignor hereby authorizes and empowers irrevocably Assignee, and appoints Assignee executor, administrator, and further assignee, as its true and lawful attorney in fact with full power of substitution and revocation; and as such Assignee, to request, demand, and receive any and all amounts relating to the Bill that may be or become due or payable or remain unpaid at any time to Assignor, including the power to sue for such amounts in its own name and right, and, further, to endorse and negotiate any checks, drafts, vouchers or similar instruments, for the payment of money in satisfaction and fulfillment thereof. Assignor expressly releases and discharges Assignee from any liability to Assignor as a result of this Assignment. In Assignee's discretion, it may file and prosecute any and all claims or take any action or initiate any proceeding either in its own name, or in the name of Assignor or otherwise, which, to Assignee, may seem to be appropriate, reasonable, and necessary, and to execute such closing documents or agreements and such waivers of the statute of limitations as may appear appropriate, reasonable, and necessary, including releases, discharges, and compromises. Assignor shall provide Assignee with copies of all communications and documents relating to any and all suits or other proceedings (administrative or legal) related to this Assignment. Assignor warrants that it (1) has not assigned, transferred, conveyed, sold or otherwise disposed of any such rights, or any claim or cause of action that is assigned to Assignee hereunder to any other person or entity; and (2) shall not do so in the future.

This Assignment is binding and irrevocable upon Assignor and Assignee and their respective legal representatives, successors, and assigns, including Assignor's spouse, if applicable. This Assignment contains the parties' entire understanding, may not be changed or terminated except by an instrument executed by both parties, and shall be governed, construed, and enforced in accordance with the laws of the State of Ohio.

IN WITNESS WHEREOF, Assignor and Assignee have caused this Assignment to be properly executed under seal on the dates shown below.

ASSIGNOR:

______________________	______________________
(Print Name)	(Print Name)
By: ______________________	*By*: ______________________
(Signature)	(Signature)
Dated: ______________________	*Dated*: ______________________

ASSIGNEE RUSSELL TOWNSHIP BOARD OF TRUSTEES:

Dated: ______________________

______________________	______________________	______________________
JUSTIN MADDEN	JIM MUELLER	GARY GABRAM

I, Charles Walder, the duly elected Fiscal Officer for Russell Township, Geauga County, Ohio, do hereby certify that this instrument was duly executed at an open meeting of the Russell Township Board of Trustees on ________________, 201_.

______________________ *Dated*: ______________

CHARLES WALDER

Cleveland Clinic

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1. Patient Information:		
Name *(First, Middle, Last)*		Cleveland Clinic Medical Record #
Current Address		City State Zip
Last 4 Digits of Social Security #	Email	Phone Number ( ) Date of Birth / /

2. Release Information From (check all that apply):	3. Release Information To:
☐ Cleveland Clinic Ohio facilities **OR** ☐ Specify Cleveland Clinic Ohio facility(ies):______	Name of Recipient
☐ Cleveland Clinic Nevada facilities	Address City/State Zip
NOTE: For release of medical records from Ashtabula County Medical Center (ACMC) and Cleveland Clinic Florida, your request must be made directly to ACMC or Cleveland Clinic Florida.	Phone Number ( ) Fax Number ( )
	Select one: ☐ Paper ☐ Secure electronic delivery (If electronic, provide recipient's email):

Purpose for Disclosure: ____________________________________
(Purpose for disclosure must be completed prior to processing. e.g., continuing care, personal use, legal)

Dates of service to release (FROM): ________________ **(TO):** ________________

☐Office Visits
☐Emergency Department Reports
☐Discharge Summary
☐Operative Reports
☐History & Physical
☐Cardiac Reports
☐Laboratory Reports
☐Radiology Reports
☐Physical/Occupational Therapy Reports
☐Homecare Records
☐Radiation Oncology Records
☐Other________________

I, the undersigned, authorize Cleveland Clinic to release health information as indicated/described above. I understand and acknowledge that the requested health information may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions, and/or alcohol/drug abuse. **This authorization does not include permission to release outpatient Psychotherapy Notes as defined below.* Release of Psychotherapy Notes requires a separate authorization.**

This authorization and consent will expire one year from the date of authorization written below, unless revoked by me (or my legal representative) through written notice presented to Health Information Management (see contact information below). Any revocation will not apply to information that has already been released in response to this authorization. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether or not I sign this authorization.

After my health information is released, my information may be re-disclosed by the recipient and may no longer be protected by law. The recipient of my health information may be charged for the service of releasing medical information. There is no charge to send records directly to my health care provider.
If Authorization is not complete, signed and dated, it may be returned and result in my information not being released until completed.

____________________ / ____________________ ____/____/____
*Signature of Patient/Patient's Personal Representative*** *Printed Name* *Date Signed*

____
Relationship, if not Patient

**Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical records.*
***If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST** accompany the request (e.g., court appointed guardian, durable power of attorney for health care). Exception: parent signing for a patient under the age of eighteen.*
***For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator, or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required to be submitted with the documents naming the administrator or executor of the estate.*

Submit request to one of the following:
(1) Health Information Management/Medical Record Department, Health Data Services Ab-7
9500 Euclid Avenue, Cleveland, OH 44195
(2) Fax: 1-216-587-8043
(3) Email: IODDMROI@ccf.org
Questions? 1-844-203-8777

NOTICE: If you send health information to Cleveland Clinic via email, please know that your message may be sent in an unencrypted email. An unencrypted email means there is a risk that the information in the email and any attachments could potentially be read by a third party when it is sent through the internet.

Revision: 04/23/2015

University Hospitals

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Records to be released from physician or medical facility: ____________________
Name

Patient Name ____________________
(Please Print) Last First M/I

Date of Birth ____________ Social Security Number (last four digits) ____________

Address ____________________ Phone Number (_____)-____________
____________________ Medical Record Number ____________
____________________ Prior MR # ____________

Treatment Date(s) ____________________

Please Release Medical Information to the Following Recipient:
Name of Person or Organization ____________________ Phone # ____________
Address ____________________ Mailstop ____________
____________________ Fax # ____________
City State Zip Code

Purpose of Disclosure ☐ at the patient's request

Description of Information to be Released:

☐ Pertinent Summary (includes all * items)

☐ Admission Form	☐ Facesheet / Demographics	☐ Physical Therapy
☐ ***Discharge Summary**	☐ Lab Reports	☐ Entire Record
☐ ***Emergency Room Report**	☐ ***Radiology Report**	☐ Physician's Notes
☐ ***History & Physical**	☐ ***EKG Report**	☐ Other ____________
☐ ***Consultation Report**	☐ ***Pathology Report**	____________
☐ ***Operative Report**	☐ ***Card Cath Report**	____________

I, the undersigned, authorize ____________________ (Disclosing Institution) and its employees to release Information from my medical records as described above. I understand and acknowledge that the medical record may contain Information regarding psychiatric disorders, Human Immune Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol, and/or drug dependence/abuse. I also understand that Information used or disclosed according to this authorization may be subject to redisclosure by the recipient and may no longer be protected. My failure to sign this authorization may result in my Information not being released.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ____________________. If I fail to specify an expiration date, event or condition, this authorization will expire in one year.

I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my failure to sign this authorization.

I understand there may be charges for the copying and release of Information and accept financial responsibility.

X ____________________ ____/____/____ ____________
Signature of Patient/Legal Representative** Date Signed Time

____________________ ☐ Patient unable to sign
Description of Legal Representative's Authority to Act on Behalf of Patient (if applicable)

☐ By signing this form as the patient's legal representative, I am certifying that there is no court order or other legal reason (such as a binding arbitration decision or final mediation agreement) prohibiting me from obtaining a copy of the requested records.
This box must be checked for ALL releases of records authorized by legal representatives.

**If other than patient's signature, a copy of legal documents MUST accompany the authorization when presented; the exception is a parent of minors under 18 years of age.

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Label

Part A:

☐ **Tripoint Medical Center** ☐ **Perry Walk-in** ☐ **Mentor Medical Campus** ☐ **Lake Health Physician Group**
☐ **West Medical Center** ☐ **Lake Health Diagnostic Centers** ☐ **Lake Health Sleep Center** ☐ **Mentor Physical Therapy**
Urgent Care Centers: ☐ **Willowick** ☐ **Tyler** ☐ **Madison** ☐ **Chardon** ☐ **Painesville**

Name of Patient: ______________________________
Last First Maiden / AKA

Address: ______________________________

Date of Birth: __________ Home Phone: __________ MR #: __________

Email Address: ______________________________

INFORMATION TO BE:

☐ Released to: __________ ☐ Obtained from: __________

I hereby authorize Lake Health / Lake Health Physician Group to release to/or obtain from the following facility, the information as specified below:

Facility/Name: ______________________________

Phone #: __________ Fax #: __________

Address: ______________________________

Date(s) of Treatment: ______________________________

Reason for Treatment: ______________________________

INFORMATION TO BE RELEASED/OBTAINED: ☐ Pertinent Summary (Includes all * items):

☐ Demographic / Facesheet ☐ Pathology Report * ☐ Radiology Report * ☐ Drug / Alcohol Info
☐ History & Physical * ☐ Consultation Report * ☐ Radiology Films ☐ EKG Report *
☐ ER Report * ☐ Entire Record ☐ Lab Reports * ☐ Cardiac Cath Report *
☐ Discharge Summary * ☐ Physical Therapy ☐ Psychiatric Info ☐ HIV / AIDS Info
☐ Operative Note * ☐ Other: __________

PURPOSE OF DISCLOSURE: ☐ Continued Treatment ☐ Personal Use ☐ Legal ☐ Other Specific Use __________

To be completed by the Organization if this authorization is for marketing, fundraising, research, or sale of Protected Health Information:
The organization will receive compensation in exchange for using or disclosing the health information as described above: ☐ YES ☐ NO

Upon admission as an inpatient or to an LHPG office practice, you were asked to sign a Consent for Treatment in which you designated that Lake Health could utilize your health information for the purpose of treatment, payment, and other health care operations as defined by law. The above information you have requested to be disclosed requires you to sign an authorization because it is being released to a third party entity outside of Lake Health.

The consent to disclose information may be revoked by you in writing at any time - except those disclosures, made in good faith that have already occurred. This consent expires one year (1) from the date of signature and applies to all services provided and protected health information created by Lake Health prior to the date of this signature.

I certify that this Authorization has been made freely, voluntarily, and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I understand that redisclosure of my medical records by those receiving the above-authorized information may be accomplished without further written authorization and may no longer be protected. I attest that if such redisclosure is made, I will not hold Lake Health responsible.

X ______________________________
Signature of Patient/Parent/Patient Representative/Physician/Other as Allowable by Law

__________ __________ __________
Relationship to Patient ☐ Patient Unable to Sign Date

If signature is other than patient's signature, a copy of all legal documents verifying the patient's personal representative MUST accompany the request (i.e. court appointed guardian, durable power of attorney for health care.) For a deceased patient: A death certificate coupled with executor of administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18.

Part B: **LH USE ONLY**

Pulled and Verified by: __________ Date: __________

Verify Photo ID by: __________ Date: __________

Method of Disbursement: ☐ Mail ☐ In-person ☐ Faxed ☐ Electronic Disclosure ☐ Other: __________

Forms of Records: ☐ Paper ______ # of pages copied ______ Cost ☐ Electronic # Pages ______, Cost ______ (Retrieval/Media Fee)

Films returned and verified by: __________ Date: __________

☐ No disclosure made (see Part C).

EX4846

Copies of Medical Records are <u>NOT</u> to be emailed directly to patients. Contact HIM DEPT: Healthport Copy Service to process this request for electronic disclosure.

0913-4846