Sharing Hope:
Making a difference in a meaningful way

Would **you** like to share your experience in a booklet we are putting together this year? ☺

We are looking for stories from people with disabilities and their Moms, Dads, Sisters, Brothers, & Grandparents!

Please consider one of the questions below. Each submission should be 250 words or less and subjected to editing for final print.

We would love if you can attach a picture or drawing along with your story too! Pictures should all be high resolution.

Booklets will distributed to local families in our community.

Any questions, please email Janet Seide at janet.seide@cchmc.org

Don't know where to begin-please consider one of the following:

- What advice would you give to families touched by DD that are just beginning their journey?
- Tell us about a moment in time….
- What would you say to a family so they do not feel alone? What advice did you receive that helped you?
- What were some of your initial fears after your child's diagnosis? How has that changed?
- What have you learned about yourself, or your child, that has surprised you?

All submissions should be emailed to DDBPFAC@cchmc.org by **7/11/16**

Thank you in advance for considering this opportunity to share your story to help others!

Cincinnati Children's
Division of Developmental and Behavioral Pediatrics

Dr. Jack Rubinstein Foundation
Serving Persons with Developmental Disorders

Cincinnati Children's

Authorization for Use and/or Disclosure of Limited Protected Health Information

MEDICAL RECORD #: _____ *(completed by CCHMC if applicable)*

****DO NOT USE THIS FORM FOR RESEARCH PURPOSES OR TO RELEASE COPIES OF THE MEDICAL RECORD****

This form gives permission for Cincinnati Children's Hospital Medical Center (CCHMC) to use and/or disclose (release) the health information of the individual below as follows:

Name: _____ Date of Birth: _____
Last First Middle

Address: _____
Address City State/Zip

Primary contact e-mail: _____ Phone: ( ) _____

Information To Use/Disclose

CCHMC may use/disclose the following health information about the individual: *(Select all that apply)*

- ☐ Photographs
- ☐ Video recordings
- ☐ Audio recordings
- ☐ Name and age
- ☐ Parent/guardian names
- ☐ City of residence
- ☐ Admission, discharge, or treated/released status
- ☐ Diagnosis, treatment, prognosis
- ☐ All of the above
- ☐ Other: _____

Purpose of Use/Disclosure

CCHMC may use/disclose this health information for the purposes described below: *(Select all that apply)*

- ☐ CCHMC communications, such as for marketing, advertising, public relations, fundraising, or other related purposes. This may include publications (print or electronic), presentations (at public or private events, on television), or internet sites (e.g., CCHMC websites, partner websites, or social media sites).
- ☐ The media, including print or television journalists.
- ☐ Professional audiences, such as publications (print or electronic), presentations or related internet sites.
- ☐ All of the above
- ☐ Other: _____

By signing below, I authorize CCHMC to use and/or disclose the health information specified in this authorization and confirm to the best of my knowledge that I am legally authorized to represent the interests of this individual.

- CCHMC will not condition treatment, payment, enrollment, or eligibility for benefits on this signed authorization.
- The health information used and/or disclosed as a result of this authorization may be subject to redisclosure by the person or entity receiving such information. At that point, it is no longer protected by the federal privacy regulations. CCHMC is not responsible for the use of information, in whole or in part, by third parties.
- Any photos, images, or other representations specified above become the property of CCHMC or its representatives.
- This authorization is given without promise of compensation. The parent/legal guardian and the individual release to CCHMC any right, title and/or interest of any kind they may have in the information or images produced.

As stated in the Notice of Privacy Practices, I understand that I may withdraw this authorization at any time. Notification of withdrawal must be done in writing and sent to the CCHMC Health Information Management (HIM) Department, 3333 Burnet Avenue, ML 5015, Cincinnati, OH 45229. This authorization will not be withdrawn or expire for situations where CCHMC has already taken action as described in this authorization. This authorization will only expire if revoked by me in writing as stated above.

Signature: _____ Date: _____

Printed name: _____

This form must be signed and dated to be valid. If the individual is an emancipated minor or 18 years of age or older, s/he is required to sign the authorization.

A copy of this authorization must be provided to the individual completing this form.

CCHMC USE ONLY

Department requesting authorization: _____

*Note: The original, signed authorization must be sent to the HIM Department Attn: ECRM (MLC 5015) within 2 weeks of obtaining signature. The department obtaining this authorization must also retain a copy, either on paper or electronically, for internal tracking purposes.