



Mailing Address

P.O. Box 8810
Middletown, Ohio 45042-9813

Driving/Shipping Address

One Medical Center Dr.
Franklin, Ohio 45005-1066
(513) 424-2111

AtriumMedCenter.org

For Junior Volunteer Applicants

Thank you for your interest in the volunteer program at Atrium Medical Center. We have a variety of openings that appeal to most people and our volunteers find that their time here provides them with activities they enjoy while giving them the chance to help others.

Please print:

- The Application
- Physician Form
- Medical Information/Patient Access HIPAA privacy Form (fill in the highlighted areas)
- A Recommendation Form, which is usually completed by a teacher or counselor at your school. During summer months, the form may be completed by an employer, pastor or other adult who knows you well enough to act as a reference for you.

Please take the completed HIPAA Privacy Form to your doctor along with the Physician Form. Your doctor can either mail the physician form or fax it to us at the number at the top of the form.

You may bring your application to the Volunteer Office on the main level of the hospital. If you stop at the Information Desk, the staff will give you directions to our office. Or you may mail the materials to us.

And please ask your references to mail the completed reference forms to:

Volunteer Services Manager
Atrium Medical Center
P.O. Box 8810
Middletown, OH 45042

Once we have received all of your paperwork, we will call you if we have an opening on a day that you are available. If we do not have an opening, we will put you on our waiting list.

If you need any additional information, please call the Volunteer Office at (513) 420-5201 or email PPLane@AtriumMedCenter.org.



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**Please have your personal physician complete this form
and mail or fax it to Volunteer Services:
Phone: (513) 420-5201, Fax: (513) 705-4504**

Dear Physician:

The young person listed below has applied to become a volunteer at Atrium Medical Center. His/her parent has signed below, granting permission for you to release medical information to the volunteer office.

Many of our volunteers work in direct contact with our patients or their families and perform a variety of tasks without constant supervision. We would appreciate your frank appraisal of this candidate. This procedure was designed to safeguard the patients and to protect the hospital from damaging incidents, as well as to protect a person who is interested in volunteering, but not physically or mentally able to perform the required tasks.

You may indicate blanket approval for any type of service, or you may impose some restrictions such as: no lifting; no pushing wheelchairs or heavy carts; or no patient contact because of a physical or emotional problem. Please use the section below to list restrictions and for any comments. We appreciate your prompt response in order to help us place this volunteer.

Yours truly,

Priscilla Lane
Manager, Volunteer Services
(513) 420-5201

I give permission for my child's physician to release relevant medical information to the Volunteer Services Office.

Parent's Signature _____

Please print the following information:

Volunteer name (first) _____ (last) _____ (other last name(s), previously used) _____

Address _____ City _____ Zip _____

Dates of first and second rubella shot or test showing immunity: _____

Physical ability -- please list any restrictions: _____

Physician comments: _____

Physician Signature _____

ATRIUM USE ONLY: This Section completed by Atrium personnel.
 Request Approved
 Request Denied (Complete Patient Access Denial Form)
 NA (Information released to persons other than the patient)
Date: _____ **Initials:** _____



Authorization For Release of Medical Information/Patient Access Form

Patient's Name: _____ **Unit #:** not applicable **Acct #:** not applicable

Birth Date: _____ **Social Security Number:** _____

Service Date/Type(s): not applicable
 (Please specify whether inpatient, Clinic, Emergency Room, etc.)

I, the undersigned, hereby authorize (insert name of physician/practice) _____ to release any information contained in the above named patient's medical records, with no limitations, including any information concerning treatment for psychiatric illness, alcohol and/or drug abuse, HIV test results, diagnosis of AIDS, or AIDS related condition, respecting the above service dates to the individual(s) or organization(s) listed below.

INFORMATION REQUESTED

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Face Sheet | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> X-ray Reports | <input type="checkbox"/> Pathology Reports / materials |
| <input type="checkbox"/> History / Physical | <input type="checkbox"/> Physician Orders | <input type="checkbox"/> Consultation(s) | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> EKG Interpretations | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Copy of Entire Record |
| <input checked="" type="checkbox"/> Other - Please Specify: <u>Immunization dates (MMR only) and restrictions that would affect the individual's ability to volunteer safely</u> | | | |

Unless otherwise revoked this authorization will expire on the following date, event or condition, i.e. end of research: **60 days from date of signature below**. If the expiration date, event, or condition is not specified, this authorization will only include the service dates as listed above. It is the responsibility of the recipient of this information to notify our facility when additional information is needed as defined within the scope of this authorization

Information to be released to: Volunteer Services Manager
Address: _____ Atrium Medical Center, P.O Box 8810
 _____ Middletown, OH 45042

This information is to be released for the purpose of: At the request of the patient **OR** Other (Please specify below):
To meet hospital Infection Control Guidelines (immunity to rubella) and any limitations for the safety of the volunteer, patients and visitors

I understand that I may revoke this authorization in writing at any time, except if Atrium Medical Center has already released the information based on this authorization. I can revoke this authorization by sending a written request attention to the Medical Record Department.

I understand that I am not required to sign this authorization form and that Atrium Medical Center will not condition the provision of treatment or payment to me on the signing of this authorization, except that Atrium Medical Center may condition the provision of research-related treatment to me on the signing of this authorization for the use or disclosure of my personal health information for such research. Atrium Medical Center may also condition the provision of health care to me that is solely for the purpose of creating protected health information for disclosure to a third party on the signing of this authorization.

<p>Signature of patient or representative: _____ <i>If you are the representative of the patient, describe the scope of your authority to act on the patient's behalf. Please check one below:</i> <input type="checkbox"/> Guardian <input type="checkbox"/> Parent of Minor <input type="checkbox"/> Power of Attorney Over Healthcare</p>	<p>Date: _____ <i>This authorization will be accepted up to 60 days from date of signature.</i></p>
<p>Signature of witness: _____</p>	

ANY REDISCLOSURE OF MEDICAL INFORMATION BY THE RECIPIENT IS PROHIBITED. I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations
A photocopy of this authorization is to be accepted the same as the original.

