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This certifies that I have been given a copy of the SWICFT Institute's Notice of Privacy Practices for Protected Health Information (HIPAA) and Patient Privacy Rights.

Your physician also has remote access to the electronic medical record of the NCH Healthcare System and can view any testing or treatments provided to you at an NCH facility. Your permission is required to allow your physician remote access to your medical records. I therefore hereby authorize the physicians of the SWICFT Institute listed above access to my NCH medical record for care or treatment.

I am aware that I may contact the SWICFT Institute Privacy Officer at any time if I have questions regarding my personal chart and its contents.

_____ _____

Signature of Patient **Date**

_____ _____

Patient Name (Printed) **Date of Birth**