Giving Hope to Those in Need

Medical Doctor's Certification for Flight

I ______________________________________ do hereby certify that my patient
Doctor's name (printed or typed)

______________________________________ is medically stable and can safely be
Patient's name (printed or typed)

transported in general aviation, non-pressurized aircraft, that are referred by Mercy Flight, without charge, for the purpose of transporting the patient to or from the named facility.

____ ______________________ ________
Facility name (printed or typed) City State

I further certify that said patient is not on any medication that may cause adverse effects at altitudes consistent with general aviation, non-pressurized aircraft.

So certified on this date ________________________________
Date of certification

____
Doctor's signature

__________________________________ _____________
City State

Return this completed form to:

Mercy Flight
P.O. Box 477
Goodland, IN 47948
219-297-3500, fax 219-297-4554
E-mail MercyFlightIndiana@Earthlink.net

Giving Hope to Those in Need

MERCY FLIGHT
P.O. BOX 477
GOODLAND, IN 47948
219-297-3500

Important Information

for Mercy Flight Recipients

Enclosed you will find the Mercy Flight Waiver of Liability and Release for Information and Photos, Notice of Privacy Practices and Doctor's Certification forms. **These forms must be properly filled-out and returned to Mercy Flight before a flight referral can be made.** These forms may be faxed for expedience, but the fax must be followed-up by mailing the hard copy, with original signatures, for our permanent records. Thank you for your attention to this requirement.

The pilot scheduled for your flight will be in contact with you at least 24 hours prior to departure to brief you with the important details of the flight. Please be sure to obtain this pilot's telephone number as there may be a need for further contact should your status change. If there needs to be any change in the flight, such as origin, destination or departure time, contact your pilot as soon as you are aware of the change.

You are responsible for any and all ground transportation that may be needed. Be sure to arrive at the airport at least 30 minutes prior to departure. You must discuss the weight of any baggage with the pilot. **WEIGH YOUR BAGGAGE.** Do not attempt to take more baggage weight than what was approved by the pilot. If oxygen bottles, wheel chairs etc. need to be transported, be sure to discuss this with the pilot during the initial contact. The pilot of the aircraft has the final word and authority as to the conduct of any aspect of the flight. No smoking, eating or drinking is permitted in or near the aircraft. Please limit your drinking within 4 hours of departure time, especially coffee, tea and soda.

Mercy Flight, pilots or flight coordinators cannot be held responsible for flight cancellations due to weather or any other unforeseen circumstances.

It is our mission to refer you to safe, rapid and comfortable air transportation that will move you to the required destination. Our mission is accomplished only after you are safely returned to your home.

To schedule your return flight, please call Mercy Flight at 219-297-3500. Please give the Flight Coordinator as much lead time as possible to arrange the flight. Please be aware that all flights are subject to weather, availability of pilots and aircraft. We will do our best to ensure a flight is available when needed.

Initial Contact Information

Screener: ______________________ Date____________________

Caller Name: __________________________________Phone #__________________

Passenger #1 Name: ______________________________ weight:_______age:_____

Passenger #2 Name: ______________________________ weight:_______age:_____

Passenger #3 Name: ______________________________ weight:_______age:_____

Reason for flight: ____

____

____

Origination address: ____

____

Origination airport:______________________________________Identifier: ________

Destination address: ____

____

Destination airport:______________________________________Identifier: ________

Preferred dates of flight: ____

Fax #: _____________________________

Adjust gross income on last years tax return: _________________________________

Weight of all baggage: ____

Misc.: ____

____

Mercy Flight
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Who We Are
This Notice describes the privacy practices of **Mercy Flight**. It applies to your medical information, including your medical record for all services provided to you and by our volunteer pilots.

II. Our Privacy Obligations
We are required by law to maintain the privacy of your health information ("Protected Health Information" or "PHI") and to provide you with this Notice of our legal duties and privacy practices with respect to your Protected Health Information. When we use or disclose your Protected Health Information, we are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

III. Permissible Uses and Disclosures Without Your Written Authorization
In certain situations, which we will describe in Section IV below, we must obtain your written authorization in order to use and/or disclose your PHI. However, we do not need any type of authorization from you for the following uses and disclosures:

A. Uses and Disclosures For Treatment, Payment and Flight Operations. We may use and disclose PHI, but not your "Highly Confidential Information" (defined in Section IV.C below), in order to transport you, obtain linked services with other similar organizations, as detailed below:

Transport. We use and disclose your PHI to provide appropriate volunteer pilot referral. and other services to you--for example, to diagnose and treat your injury or illness. In addition, we may contact you to provide logistical reminders or information about transport alternatives We may also disclose PHI to other transportation providers involved in your trip.

Transportation Co-ordination. We may use and disclose your PHI for our transport care referral operations, which include internal administration and planning and various activities that improve the quality and effectiveness of the assistance that we arrange for to you. For example, we may use PHI to evaluate the quality of our operations. We may also disclose PHI to your other volunteer pilots when such PHI is required for them to appropriately help you.

B. Disclosure to Relatives, Close Friends and Other Caregivers. We may use or disclose your PHI to a family member, other relative, a close personal friend or any other person identified by you when you are present for, or otherwise available prior to, the disclosure, if we (1) obtain your agreement; (2) provide you with the opportunity to object to the disclosure and you do not object; or (3) reasonably infer that you do not object to the disclosure.

If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interests. If we disclose information to a family member, other relative or a close personal friend, we would disclose only information that we believe is directly relevant to the person's involvement with your health care or payment related to your health care. We may also disclosure your PHI in order to notify (or assist in notifying) such persons of your location, general condition or death.

C. Fundraising Communications. We may contact you to request permission to use elements of your trip in connection with public relations, outreach, development, and educational aspects of **Mercy Flight's** operations.

D. Judicial and Administrative Proceedings. We may disclose your PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

E. Law Enforcement Officials. We may disclose your PHI to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena.

F. Decedents. We may disclose your PHI to a coroner or medical examiner as authorized by law.

G. Organ and Tissue Procurement. We may disclose your PHI to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

H. Health or Safety. We may use or disclose your PHI to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.

I. Specialized Government Functions. We may use and disclose your PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances.

J. As required by law. We may use and disclose your PHI when required to do so by any other law not already referred to in the preceding categories.

IV. Uses and Disclosures Requiring Your Written Authorization
A. Use or Disclosure with Your Authorization. For any purpose other than the ones described above in Section III, we only may use or disclose your PHI when you grant us your written authorization on our authorization form ("Your Authorization"). For instance, you will need to execute an authorization form before we can send your PHI to your life insurance company or to the attorney representing the other party in litigation in which you are involved.

B. Uses and Disclosures of Your Highly Confidential Information. In addition, federal and state law requires special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including the subset of your PHI that: (1) is maintained in psychotherapy notes; (2) is about mental health and developmental disabilities services; (3) is about alcohol and drug abuse prevention, treatment and referral; (4) is about HIV/AIDS testing, diagnosis or treatment; (5) is about venereal disease(s); (6) is about genetic testing; (7) is about child abuse and neglect; (7) is about domestic abuse of an adult with a disability; or (8) is about sexual assault. In order for us to disclose your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written authorization.

V. Your Rights Regarding Your Protected Health Information

A. For Further Information; Complaints. If you desire further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to your PHI, you may contact our Privacy Office. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy Office will provide you with the correct address for the Director. We will not retaliate against you if you file a complaint with us or the Director.

B. Right to Request Additional Restrictions. You may request restrictions on our use and disclosure of your PHI (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction. If you wish to request additional restrictions, please request so in writing. We will send you a written response.

C. Right to Receive Confidential Communications. You may request, and we will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.

D. Right to Revoke Your Authorization. You may revoke Your Authorization, Your Marketing Authorization or any written authorization obtained in connection with your Highly Confidential Information, except to the extent that we have taken action in reliance upon it, by delivering a written revocation statement to the Privacy Office identified below

F. Right to Amend Your Records. You have the right to request that we amend Protected Health Information maintained in your medical record file or billing records. If you desire to amend your records, please submit such a request in writing. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply. In the case of a requested amendment concerning information about the treatment of a mental illness or developmental disability, you have the right to appeal our decision not to amend your Protected Health Information to an Illinois court.

G. Right to Receive An Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures of your PHI made by us during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, we will charge you $0.50 per page of the accounting statement.

H. Right to Receive Paper Copy of this Notice. Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such notice electronically.

VI. Effective Date and Duration of This Notice

A. Effective Date. This Notice is effective on April 14, 2003.

B. Right to Change Terms of this Notice. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all Protected Health Information that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the new one on our Internet site at ***http://home.earthlink.net/~MercyFlightIndiana*** You also may obtain any new notice by contacting the office.

VII. Privacy Office

You may contact the Privacy Office at:

Mercy Flight
P.O. Box 477
Goodland, IN 47948

By signing below, I hereby acknowledge receipt of **Mercy Flight's** Privacy Practices and consent to the uses and disclosures described in the Notice of Privacy Practices.

_______________________________________ __________________ ____, 20____

Signature of Patient (Legal or Personal Representative) Date of Signature

Print Patient Name

Please FAX this signed document to Mercy Flight at 219-297-4554

Giving Hope to Those in Need

Waiver of Liability and Release for Information and Photos

To Whom it May Concern:

In consideration of their providing free air transportation and solely for my benefit, I/We the undersigned do hereby release the non-commercial and non-profit:

- The Mercy Flight organization
- Other Mercy Flight or charitable flight organizations
- The volunteer pilots
- The aircraft owner
- Volunteers, employees, directors and other personnel associated with Mercy Flight

fully and without reservation, from any and all claims whatsoever of culpability, responsibility, fault or liability for any inadvertent injury and/or damage while boarding, while aboard or while departing any aircraft or vehicle referred by Mercy Flight.

With full knowledge of all state, federal and local health privacy laws, and the Mercy Flight Notice of Privacy Practices, I/We further authorize and release Mercy Flight, its volunteers, employees, directors or agents, to use My/Our medical information and photographic or other likeness for promotional purposes.

Furthermore, I/We do herewith, unequivocally waive and deny, for Myself/Ourselves and all My/Our assigns, all rights to pursue any action against:

- The Mercy Flight organization
- Other Mercy Flight or charitable flight organizations
- The volunteer pilots
- The aircraft owner
- Volunteers, employees, directors and other personnel associated with Mercy Flight

for any action or inaction executed or suffered by them in good faith. In the event one or more of the elements in this waiver are for any reason held to be invalid or unenforceable in any respect, it shall not affect any other provision of this waiver.

Signature__________________________ Signature______________________________

Printed Name___________________________ Printed Name_______________________

Guardian for:____________________________ Guardian for:______________________

Street______________________________ Street_______________________________

City/State__________________________ City/State_____________________________

Zip Code___________________________ Zip Code_____________________________