Ohio Attorney General's Office
Bureau of Criminal Investigation
Investigative Report

2024-1015
Officer Involved Critical Incident - 100 Block 8th Street, N.E. New Philadelphia, Ohio 44663 Tuscarawas, County

Investigative Activity:	Records Received, Review of Records
Involves:	[redacted] (S)
Date of Activity:	06/26/2024
Activity Location:	BCI - Richfield - 4055 Highlander Parkway, Richfield, OH 44286
Author:	SA John P. Tingley, #154

Narrative:

On June 26, 2024, Ohio Bureau of Criminal Investigation (BCI) Special Agent (SA) John Tingley (Tingley) received and reviewed medical/treatment records for Tuscarawas County Sheriff's Office (TCSO) [redacted] ([redacted] from both Aultman Hospital in Canton, Ohio, and the Cleveland Clinic Akron General Hospital.

The records were obtained after [redacted] signed consent to release forms for both Aultman Hospital and Cleveland Clinic Akron General Hospital.

The following information is derived from the complete files provided by each hospital. The information listed is that which the author deems to be the most helpful in understanding the extent of the injuries suffered by [redacted]

Aultman Hospital

[redacted] was transported to the Emergency Department of the Aultman Hospital by the Dover Fire Department ambulance and was admitted to Aultman Hospital at 2207 hours on March 31, 2024. [redacted] presented to the Emergency Department staff with a gunshot wound to the left index finger and pain to the right leg/shin. [redacted]s care consisted of: wound treatment; x-rays: laboratory tests; and dispensed medication for pain. After receiving initial treatment, it was determined by medical staff that [redacted] needed to be transferred to Cleveland Clinic Akron General Hospital for further advanced treatment. Accordingly, at 23:47 hours, [redacted] was discharged and was transported to the Cleveland Clinic Akron General Hospital via Stark-Summit ambulance.

Cleveland Clinic Akron General Hospital

[redacted] was transported to the Emergency Department of the Cleveland Clinic Akron General Hospital by the Stark-Summit ambulance and was admitted to the Cleveland Clinic

Akron General Hospital at 0228 hours on April 1, 2024. [redacted] presented to the Emergency Department staff with a gunshot wound which caused an "[redacted] as well as pain on the right leg/shin. [redacted] s care consisted of: wound treatment; x-rays: laboratory tests; and dispensed medication for pain. [redacted] also had a procedure done by a doctor with the Orthopedics Department. [redacted] was discharged on April 2, 2024 at 1625 hours.

A copy of the medical records authorization for release of medical records form for both Aultman Hospital and the Cleveland Clinic Akron General Hospital are attached to this report.

Copies of the medical records from both Aultman Hospital and the Cleveland Clinic Akron General Hospital were submitted as Reference Item E to the physical case file.

Attachments:

Attachment # 01: 2024-1015 MEDICAL RECORDS AUTHORIZATION FORMS

References:

REF ITEM E - [redacted] MEDICAL RECORDS

AULTMAN

Authorization for Release of Health Information

[redacted] 2/28/1993

Name Date of Birth Medical Record Number (if known)

[redacted] New Philadelphia OH 44663 [redacted]

Address City State/Zip Phone Number

Health information to be disclosed:

Dates of Service (if known): From 3/31/24 To Current

- ☐ Emergency Department
- ☐ Radiology Reports
- ☐ Operative Reports
- ☐ Complete Medical Record
- ☐ Lab Reports
- ☐ Pathology Reports
- ☐ Discharge Summary
- ☐ Office Notes
- ☐ Billing Reports
- ☐ History & Physical
- ☐ EKG
- ☐ Medication Records
- ☐ Research Records
- ☒ Other (Specify in detail): All

I would like: ☐ To inspect medical records ☐ A copy of medical records

Reason for Disclosure: ☐ At the request of the patient ☐ Other (describe):

This information may be released from:

Organization or health care provider making disclosure

Address

City State/Zip

( ) ( )

Phone Number Fax Number

This information may be disclosed to: ☐ Self

Individual or organization receiving information

Address

City State/Zip

( ) ( )

Recipient Phone Number Recipient Fax Number

I hereby authorize the use or disclosure of personal health information about me as described above. I understand if a request to inspect the record is made, nothing may be removed, taken apart, or noted in or on any portion of the medical record. 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 redisclosed by such a person or entity and will likely no longer be protected by the federal privacy regulations. As described in the Notice of Privacy Practices of Aultman, I understand that I may revoke this authorization in writing any time, except to the extent that action has been taken by Aultman in reliance on this authorization, by sending a written revocation to **Aultman Medical Records Department, 2600 Sixth Street SW, Canton, Ohio 44710**. 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 this authorization is voluntary and Aultman will not condition treatment, payment, enrollment or eligibility for benefits on this authorization. I understand and acknowledge that my medical record may contain information relating to Mental Health, Alcohol/Drug Abuse and/or Human Immune Virus/Acquired Immune Deficiency Syndrome, or other sensitive information, and I expressly consent to the release of any such information contained in the record designated above. This release is sufficient for the purpose of release of Alcohol/Drug diagnosis and treatment, HIV test results or diagnosis.

Signature: [redacted] Date: 5/22/24

If the personal representative of the individual is signing this authorization, please attach document(s) of the personal representative's authority to act on behalf of the individual, if any:

Patient Representative's Signature:_____ Date:_____

Description of Authority:_____

For Office Use Only: Pages Released: Date: Initials:

FORM 434 (91549) R: 09/13

Cleveland Clinic
Akron General

Medical Record Number: _____

Account Number or Date(s) of Service: 3/31/24 to current

Please Print:

Patient Name: [redacted] (Last) [redacted] (First) [redacted] (Middle Initial)

DOB: 2/28/93 Social Security Number: [redacted]

Address: [redacted] (Street) New Philadelphia, OH 44663 (City/State/Zip Code)

Phone Number: [redacted] Email: _____

Responsible Party (if other than patient): ☐ Patient ☐ Guardian ☐ Power of Attorney ☐ Executor of Estate

If responsible party is not the patient, a copy of legal documents MUST accompany the authorization when presented. The only exception is that of a parent of a minor child under 18 years of age.

I, the undersigned, hereby authorize (check all that apply): ☑ Cleveland Clinic Akron General, ☐ Edwin Shaw Rehabilitation Institute, ☐ Lodi Community Hospital to use or disclose my personal health information as described below to:

Name of Recipient: _____ Phone Number: _____

Address: _____ (Street) _____ (City/State/Zip Code)

Dates of Service to Disclose: 3/31/24 to current

Purpose of Disclosure: BCI investigation

Information may be released (check all that apply): ☑ Written ☑ Electronic/CD ☑ Email

SPECIFIC INFORMATION REQUESTED:

☐ ADMISSION FORM	☐ EMERGENCY RECORD*	☐ OTHERS: _____
☐ PHYSICIAN ORDERS	☐ PROGRESS NOTES	_____
☐ PATHOLOGY REPORTS*	☐ OPERATIVE / PROCEDURE REPORTS*	_____
☐ RADIOLOGY REPORTS*	☐ LABORATORY REPORTS*	_____
☐ CONSULTATION RECORDS*	☐ ECHOCARDIOGRAM/STRESS TEST*	_____
☐ DISCHARGE SUMMARY*	☐ HISTORY AND PHYSICAL REPORT*	☒ COMPLETE CHART
☐ OBSTETRICAL RECORDS*	☐ MEDICATION RECORDS	☐ PERTINENT SUMMARY (includes (*) reports only)
☐ NEUROLOGY REPORTS*		

If requesting itemized billing, please call 866-621-6385.

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 I have a right to revoke this authorization (in writing) at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will expire in 1 year.

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 redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

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 for those charges.

Authorizing Signature: [redacted] Date: 5/22/24

This form is HIPAA Compliant.

**Prohibition Against Re-Disclosure: This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R., Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client. (These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure.)

Cleveland Clinic
Akron General

DATE:

PART OR ALL OF REQUEST FOR RELEASE / ACCESS DENIED

- ☐ The authorization/access request was not signed by the patient.
- ☐ The authorization/access request is dated greater than 1 year upon receipt of.
- ☐ The authorization/access request form is signed by the patient's representative and the representative has not provided information on the source of his/her authority to act for the patient consistent with our Verification Policy.
- ☐ Part or all of the authorization/access request relates to a record that is not maintained by our facility.
- ☐ The authorization/access request does not contain enough patient information to locate patient. Please provide the following information: _____
- ☐ Part or all of the authorization/access request relates to information that is not a part of the designated record set.
- ☐ Part or all of the authorization/access request relates to psychotherapy notes.
- ☐ Part or all of the authorization/access request relates to information that has been compiled in anticipation of or for use in civil, criminal, or administrative proceeding.
- ☐ Part or all of the authorization/access request relates to information that is not accessible pursuant to the Clinical Laboratory Improvements Act.
- ☐ Part or all of the authorization/access request relates to information obtained by us in the course of research still in progress that includes treatment of the patient and the patient agreed to the denial of release/access when consenting to participate in the research.
- ☐ A Licensed Health Care Professional has ordered that part or all of the information not be provided to the patient or the patient's representative.
- ☐ Part or all of the requested for release/access relates to information that was obtained by us from a non-health care provider under a promise of confidentiality and access would likely reveal the source of the information.

STATEMENT OF RIGHTS WHEN ACCESS IS DENIED

Whenever your request for access to your health information is denied by Cleveland Clinic Akron General in whole or part, you have the right to file a complaint regarding this denial to us by submitting the complaint at any time in writing to ***Health Information Management, 1 Akron General Ave., Akron, Ohio 44307.*** You also have the right to file a written complaint within 180 days of this notice to the Secretary of the U.S. Department of Health and Human Services in Washington D.C.

When a licensed medical care professional has determined that you should not be given access to some or all of the information you request, you have the right to have this denial reviewed. If you request such a review, we will forward your request for access to a licensed health care professional, of our choosing, who was not involved in the original denial decision. This reviewing official will determine whether to approve or deny your access request. We will comply with the decision of the reviewing official and will provide you notice of the decision. If you wish a review of your denial for access, so indicate by checking the box below and returning this form to the Director of Medical Records at the above address.

We are only required to provide for a review of your access denial if the request was denied for the following reason as indicated on the Access Approval/Denial portion of this form:

- ☐ The requested records are not available to you by order of your health care provider who has stated that the records may not be accessed by you.
- ☐ I would like the denial of my request for access reviewed by another licensed health care professional.

Name: _____

Address: _____

Phone Number: _____

Signature: _____ Date: _____

Note that no review request will be processed unless you or your legal representative has signed this form. Return this form within 30 days of receipt of this notice as listed above.

ACCESS & AUTHORIZATION FOR RELEASE OF INFORMATION

TAB (MAUVE): CONSENTS & MISC.