Cincinnati Children's
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Authorization for Use and/or Disclosure of Protected Health Information (PHI)

MEDICAL RECORD #: _____ CSN / ACCT #: _____ *(completed by CCHMC)*

This form authorizes Cincinnati Children's Hospital Medical Center (CCHMC) to use and/or disclose protected health information in the manner described below and is voluntary. CCHMC will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization. The information used or disclosed as a result of this Authorization may be subject to re-disclosure by the person or entity receiving such information, and no longer protected by the federal privacy regulations. Please see the back of this form for tips for requesting medical record copies.

NOTE: Failure to complete each section of this form in its entirety *(including dates needed) may significantly delay the processing of your request*.

Patient Information

Patient (Pt) Name: _____ Gender: ☐ Male ☐ Female
Last First Middle Maiden (if applicable)

Date of Birth: _____ Phone: ( ) _____

Name of Patient/Parent/Legal Guardian (LG) Completing Form: _____

Patient/Parent/Legal Guardian Email Address: _____

Patient/Parent/Legal Guardian Address: _____

Release To

Name: _____ Organization (if applicable): _____

Street Address: _____

City/State: _____ Zip Code: _____ Telephone: ( ) _____

Information May Be Sent Via (*Note: Radiology images can only be placed on CD and mailed or picked-up*):

☐ US Mail ☐ MyChart (released to Patient/Parent/Legal Guardian **only**) ☐ Picked Up (Individual to Pick-up): _____

☐ Reviewed in Health Information Management (HIM) (Appointment Necessary)

I would like copies provided in the following format: ☐ Paper- see fees on back of form ☐ CD- cost not to exceed $50 plus shipping and handling.

☐ Verbal communication only between CCHMC care providers and person/entity named above. (HIM Department does not release PHI over the phone).

Purpose (Optional for Pt/Parent/LG)

Records are to be released for the following purpose(s): *(please select all that apply)*

☐ Medical Care, patient has an appointment on the following date: _____

☐ Attorney/Legal ☐ Personal ☐ Insurance ☐ Disability/SSI ☐ Education ☐ Military ☐ Other: _____

Information to Release

Dates of Treatment Requested: Last 2 years of active treatment will be provided unless specified. Dates: _____

☐ Medical Record Abstract – pertinent information generally used for continued care/personal use/disability. *(The following items are included in a Medical Record Abstract.)*

- ☐ Discharge Summary
- ☐ Emergency Department Record
- ☐ History & Physical
- ☐ Inpatient Consult Reports, Specify MD/Specialty: _____
- ☐ Outpatient Clinic Notes, Specify Clinic(s): _____
- ☐ Other Tests, please specify: _____
- ☐ Operative Reports
- ☐ Radiology Reports
- ☐ Lab Reports

Other Information Requested:

- ☐ Immunizations
- ☐ Radiology Images
- ☐ Registration Sheets
- ☐ Other: _____
- ☐ Other: _____

Patient/Parent/Legal Guardian

Unless otherwise revoked, this Authorization will expire one (1) year from the date signed or, if specified on the following date (optional): _____. Unless otherwise noted, records documented after the signature date below will be released upon verbal or written request of the Patient/Parent/Legal Guardian for up to one year from the date of signature. This Authorization may be revoked at any time. However, the revocation will not apply to uses or disclosures occurring prior to our receipt of your revocation request. To revoke the Authorization the patient/parent/legal guardian must submit a revocation request in writing to the HIM department at the address below. If CCHMC requests this Authorization for its own use or disclosure, a copy of this Authorization must be provided. Please refer to the CCHMC Notice of Privacy Practices.

I, the undersigned, hereby authorize CCHMC to use and/or disclose information from the medical or financial record as specified above. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above mentioned entity.

Signature of Patient: _____ Date: _____
(if 18 years of age or older OR is an emancipated minor)

Signature of ☐ Parent ☐ Legal Guardian ☐ GAL/CASA: _____ Date: _____
Note: If Legal Guardian, GAL/CASA is checked, documentation establishing relationship must be provided, or on record, in order to comply with this request.

Submit

Verify that all sections are completed in full, signed and dated. Upon completion, please do one of the following:

Mail the completed form via US Mail to:	**Fax the Form to:**	**E-mail the Form to:**
Cincinnati Children's Anderson Primary Care Center 7502 State Rd Suite 3350 Cincinnati, OH 45255	(513) 231-6739	Andersonprimarycare@cchmc.org

Request Has Been Fulfilled: ☐ Yes, Name _____ Date _____ Page Count _____

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Tips for Requesting Medical Record Copies

DID YOU KNOW?

✓ **Did You Know:** Authorization forms signed by someone other than the Patient (if 18 years of age or older, or an emancipated minor*), or the patient's parent (if under the age of 18) **must** be accompanied by guardianship documentation signed by a Judge or Magistrate.

> ***Emancipated Minor**: (from ORC 2919.121) A minor shall be considered "emancipated" if the minor has married, entered the armed services of the United States, become employed and self-subsisting, or has otherwise become independent from the care and control of (his/)her parent, guardian, or custodian.

✓ **Did You Know:** Requests for "**ALL**" information (which includes for example: progress notes, nurses notes, flowsheets, consent forms, etc.) can considerably delay processing of your request and become very costly. If you need assistance determining what to request, please ask the person/entity authorized to receive the information what they need, or contact a Health Information Management (HIM) Department representative at (513) 636-4217, Option 1 and we will be happy to assist you.

✓ **Did You Know:** When requesting dates of service, an Abstract (see definition below) of the medical records from the last 2 years of active treatment will be released, unless otherwise specified. If additional records are needed, please specify dates.

✓ **Did You Know:** If the information requested is for continuing patient care, patient/parent/legal guardian use or disability purposes the receiving entity generally only wants an **Abstract** of pertinent information.

Medical Record Abstract contains the following documentation:

- Discharge Summary – from an Inpatient stay, this document is a summary of the care, treatment, services provided and progress toward established goals of an inpatient stay
- Emergency Record – this record documents a summary of the care, treatment and services provided for a visit to the emergency room
- History & Physical – this form details the present illness or care needs and denotes any relevant past history
- Inpatient Consultation Report(s) – this report documents the findings of a physician asked to examine a patient during an inpatient or observation stay
- Operative/Procedure Report(s) – this report details the surgeon/proceduralist's findings, technical procedures used, specimens removed and postoperative diagnosis
- Outpatient Clinic Note(s) – notes from outpatient office/therapy visits
- X-Ray Reports, Labs or Other Tests – radiology, lab results, and other tests including echocardiograms and EKG's

✓ **Did You Know:** Records sent to patient/parent/legal guardians or to providers for continuing patient care, are **not** charged. If records are being sent to another person/entity, there may be a charge, see below.

The person/entity identified to receive records will be sent a prepayment invoice upon determination of total cost.

Paper Copies	$0.53/page
CD	$0.52/page (cost not to exceed $50 plus shipping and handling)
Radiology Images	$10.00 per study
Shipping/Handling	$ Actual Cost based on US Postal Service rates (waived if picked up)

Fees are reviewed periodically and are based on the State of Ohio ORC 3701.742 or the HIPAA HITECH ACT.

✓ **Did You Know:** If you did not specify records to be released on paper or CD, the records will be released on CD if 500 pages or more.

✓ **Did You Know:** The Health Insurance Portability and Accountability Act (HIPAA) allows healthcare providers **30 days to process records** requested by patients/parents/legal guardians with an acceptable extension period of 30 days when required. CCHMC strives to provide records more timely, however occasionally the full 30 days are required.

✓ **Did You Know:** If you've selected "**Reviewed in HIM**", an appointment needs to be scheduled. An HIM Department representative will contact you when the records are ready to be reviewed.

✓ **Did You Know:** If you've requested release of records through the patient's CCHMC MyChart account, please note that only those records documented in the electronic medical record system can be sent through MyChart. Also Radiology images cannot be sent through MyChart. Images are placed on a CD and sent through the mail.