

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 as described below. This is voluntary. Cincinnati Children's will not condition treatment, payment, enrollment, or eligibility for benefits based on this Authorization. The information used or disclosed due to this Authorization may be subject to re-disclosure by the person or entity receiving the information. This is no longer protected by the federal privacy regulations. See the back of this form for tips for requesting medical record copies.

NOTE: Failure to complete each section of this form will delay the processing of your request.

Patient Information	Patient (Pt.) Name: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> Last First Middle Maiden (if applicable) </div> 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: _____ Phone: (____) _____ Email: _____ Information May Be Sent Via (Note: Radiology images can only be placed on CD and mailed or picked-up): <input type="checkbox"/> US Mail <input type="checkbox"/> MyChart (released to Patient/Parent/Legal Guardian only) <input type="checkbox"/> Picked Up, Individual to Pick-up: _____ <input type="checkbox"/> Emailed <input type="checkbox"/> Reviewed in Health Information Management (HIM) (Appointment Necessary) I would like copies provided in the following format: <input type="checkbox"/> Paper- see fees on back of form <input type="checkbox"/> CD- cost not to exceed \$50 plus shipping and handling <input type="checkbox"/> Verbal communication only between CCHMC care providers and person/entity named above (HIM Department does not release PHI over the phone)	
Purpose <small>(optional for P/Parent/LG)</small>	Records are to be released for the following purpose(s): <i>(please select all that apply)</i> <input type="checkbox"/> Medical Care, patient has an appointment on the following date: _____ <input type="checkbox"/> Attorney/Legal <input type="checkbox"/> Personal <input type="checkbox"/> Insurance <input type="checkbox"/> Disability/SSI <input type="checkbox"/> Education <input type="checkbox"/> Military <input type="checkbox"/> Other: _____	
Information to Release	→ Dates of Treatment Requested: Last 2 years of active treatment will be provided unless specified. Dates: _____ <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <input type="checkbox"/> Medical Record Abstract - pertinent information generally used for continued care/personal use/disability <i>(The following items are included in a Medical Record Abstract.)</i> <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Operative Reports <input type="checkbox"/> Emergency Department Record <input type="checkbox"/> Radiology Reports <input type="checkbox"/> History & Physical <input type="checkbox"/> Lab Reports <input type="checkbox"/> Inpatient Consult Reports, Specify MD/Specialty: _____ <input type="checkbox"/> Outpatient Clinic Notes, Specify Clinic(s): _____ <input type="checkbox"/> Other Tests, please specify: _____ </div> <div style="width: 35%;"> Other Information Requested: <input type="checkbox"/> Immunizations <input type="checkbox"/> Radiology Images <input type="checkbox"/> Registration Sheets <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ </div> </div>	
Parent / Patient / 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. The revocation will not apply to uses or disclosures happening before to the 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: _____ <i>(if 18 years of age or older OR is an emancipated minor)</i> Signature of <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> GAL/CASA: _____ Date: _____ <small>Note: If Legal Guardian, GAL/CASA is checked, documentation establishing relationship must be provided, to comply with this request.</small>	
Submit	Verify that all sections are completed in full, signed and dated. Upon completion, please do one of the following: <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> Mail the completed form via US Mail to: Cincinnati Children's Anderson Primary Care Center 7502 State Rd Suite 3350 Cincinnati, OH 45255 </div> <div style="width: 30%; text-align: center;"> Fax the form to: (513) 231-6739 </div> <div style="width: 30%; text-align: center;"> Email the form to: Andersonprimarycare@cchmc.org </div> </div>	

Request has been filled: Yes, Name _____ Date _____ Page Count _____



Tips for Requesting Medical Record Copies

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** have a guardianship document 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.

- ✓ Requests for "**ALL**" information (which can include: progress notes, nursing notes, flowsheets, consent forms, etc.) can considerably delay processing your request. If you need help determining what to request, please ask the person authorized to receive the information what they need. You can also contact a Health Information Management (HIM) Department representative at (513) 636-8233. We will be happy to assist you.
- ✓ 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.
- ✓ If the information requested is for continuing patient care, patient/parent/legal guardian use or disability purposes the receiving entity generally wants an **Abstract** of specific information.

Medical Record Abstract contains the following documentation:

- Discharge Summary –this document is a summary of the care, treatment, services provided and progress toward 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 includes any relevant 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 or therapy visits
- X-Ray Reports, Labs or Other Tests – radiology, lab results, and other tests including echocardiograms and EKGs

- ✓ 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 or entity, there may be a charge.

The person or entity identified to receive records will be sent a prepayment invoice once the total cost is determined.

Paper Copies/CD per page	First 10 pages \$1.34/page, pages 11-50 \$.69/page, 51 pages and up \$.27/page (CD 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. They are based on the State of Ohio ORC 3701.742 or the HIPAA HITECH ACT.

- ✓ If you did not specify records to be released on paper or CD, the records will be released on CD.
- ✓ 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 quickly. Sometimes the full 60 days are required.
- ✓ If you have 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.
- ✓ If you've requested release of records through the patient's CCHMC MyChart account, please note that radiology images cannot be sent through MyChart. Images will be put on a CD and sent through the mail.
- ✓ If you are an attorney and submit a subpoena for medical records and you are not the prosecuting attorney requesting records for reasons of child abuse or neglect, please also submit the Authorization for use and/or Disclosure form signed by the patient/parent/legal guardian or a Court Order signed by a Judge or Magistrate.
- ✓ If records are requested to be picked up and are not picked up within 60 days the records will be destroyed.