Cincinnati Children's
changing the outcome together

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: ☐ 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: Records Deposition Service Organization (if applicable): _____

Street Address: P.O. Box 5054

City/State: Southfield MI ZIP Code: 48086-5054 Phone: (248) 357-3330

Email: Requests@recdep.com

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: _____

☑ Emailed ☐ 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: Pretrial discovery

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 ☐ Operative Reports ☐ Emergency Department Record

☐ Radiology Reports ☐ History & Physical ☐ Lab Reports

☐ Inpatient Consult Reports, Specify MD/Specialty: _____

☐ Outpatient Clinic Notes, Specify Clinic(s): _____

☐ Other Tests, please specify: _____

Other Information Requested:

☐ Immunizations

☐ Radiology Images

☐ Registration Sheets

☐ Other: _____

☐ Other: _____

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: _____
(*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, 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:
Cincinnati Children's Hospital Medical Center
3333 Burnet Avenue, ML 5015
Cincinnati, Ohio 45229-3039

Fax the form to:
(513) 636-6729

Email the form to:
ROI@cchmc.org

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

DTM1000