Cincinnati Children's Hospital Medical Center

# Authorization for Use and/or Disclosure of Protected Health Information

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

This form authorizes Cincinnati Children's Hospital Medical Center to use and/or disclose protected health information in the manner described below and is voluntary. Cincinnati Children's 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 rediscosure by the person or entity receiving such information, and no longer protected by the federal privacy regulations.


**Please note that each section of the form must be completed in its entirety. *Failure to specify (including dates) will delay the processing of your request*.**

**Patient Information**

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

Date of Birth: _____ Phone: ( ) _____

Parent/Guardian/Requestor Completing Form: _____

Requestor Email Address (optional): _____

*Note: Email addresses will be utilized strictly to facilitate the processing of your request. No protected health information will be conveyed in this manner.*

**Release To**

Name: _____ Organization (if applicable): _____

Street Address: _____

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

Information May Be: ☐ Mailed ☐ Reviewed Only ☐ Discussed via Telephone ☐ In Person Meeting ☐ Picked Up By: _____

☐ Verbal communication only; no records needed.

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.

**Purpose**

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

☐ Medical Care ☐ Attorney/Legal ☐ Personal ☐ Insurance ☐ Disability/SSI ☐ Other: _____

**Information to Release**

Dates of Treatment/Particular Illness/Admission Requested: _____

☐ Medical Record Abstract – pertinent information generally used for continued care/personal use.
*(See the reverse of this form for information regarding what is included in a Medical Record Abstract.)*

☐ Discharge Summary ☐ Emergency Department Record ☐ Radiology Reports ☐ Radiology Images ☐ Lab Reports
☐ History & Physical ☐ Immunizations ☐ Consultation Reports, Specify MD/Specialty: _____
☐ Operative Reports ☐ Registration Sheets ☐ Outpatient Clinic Notes, Specify Clinic(s): _____
☐ Other: _____ ☐ Other Tests, please specify: _____

**Patient/Parent/Legal Guardian Authorization**

Unless otherwise revoked, this Authorization will expire one (1) year from the date it is signed or, if specified, on the following date, event or condition (complete if desired): _____. 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. In order to revoke the Authorization the individual/parent/legal guardian must submit a revocation request in writing to the Health Information Management department at the address below. Please refer to Cincinnati Children's Notice of Privacy Practices. If Cincinnati Children's requests this Authorization for its own use or disclosure, a copy of this Authorization must be provided to the individual completing this form.

I, the undersigned, hereby authorize Cincinnati Children's Hospital Medical Center to use and/or disclose information from my (or give relationship) _____ 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(ies).

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

Signature of ☐ Parent/ ☐ Legal Guardian (check one): _____ Date: _____
Note: If Legal Guardian box is checked, documentation establishing guardianship must be provided or on record in order to comply with the above request.

**Submit**

Please verify that all sections are completed in full. Upon completion, please send the form to:

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

**OR**

Fax the form to: (513) 636-6729



Request Has Been Fulfilled: ☐ Yes, Initials _____ Date _____

*DTM1000*

# DID YOU KNOW?

## Tips for Requesting Medical Record Copies

- ✓ **Did You Know**: If the information requested is for continuing patient care the receiving caregiver generally only wants an abstract of pertinent information. This same abstract usually meets the need for individual use.

  This information is called a Medical Record Abstract and contains the following:

  - o Discharge Summary – this document is a summary of the care, treatment, services provided and progress toward established goals of an inpatient stay
  - o Emergency Record – this record documents the care, treatment and services provided for a visit to the emergency room
  - o History & Physical – this form details the present illness or care needs and denotes any relevant past history
  - o Operative Report(s) – this report details the surgeon's findings, technical procedures used, specimens removed and postoperative diagnosis
  - o Consultation Report(s) – this report documents the findings of a physician requested to examine a patient
  - o X-Ray Reports, Labs or Other Tests
  - o Clinic Note(s)

- ✓ **Did You Know**: There is a charge for medical record copies. **Requestors will be sent a prepayment invoice upon determination of total cost.** Note: This charge is waived for records sent directly to continuing care providers.

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|---|---|
| **Basic Retrieval Fee** | **$ 17.97 / request (Retrieval fee waived for patient requests; other fees apply)** |
| Pages 1 – 10 | $ 1.18/pg |
| Pages 11 – 50 | $ .61/pg |
| Pages 51 + | $ .25/pg |
| Microfilm/Microfiche | $ 2.00/pg |
| Shipping/Handling | $ Actual Cost (waived if picked up) |

Fees are reviewed on an annual basis and are based on the State of Ohio ORC 3701.742.

Records provided on CD will be provided at a cost not to exceed $50, plus shipping and handling.

- ✓ **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 for their personal use, 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 due to record availability (e.g. offsite storage return).

- ✓ **Did You Know**: Requests for **all** information (including progress notes, consent forms, registration sheets, etc) can delay processing and become very costly. If you need assistance determining what to request, a Patient Information Coordinator (513) 636-8233 will be happy to assist you.

- ✓ **Did You Know**: Requests for information signed by someone other than the patient's parent must be accompanied by guardianship documentation signed by a Judge or Magistrate.

Cincinnati Children's