Akron Children's Hospital

HIPAA AUTHORIZATION to RELEASE MEDICAL RECORDS (TO Children's)

Please PRINT and fill out entirely.

MRN

_____

Facility Use Only

Patient Information

Patient Name: _____
Last First Middle (any previous name) Date of Birth

_____
Patient Street Address City State Zip Phone

Release TO

Release Information TO Akron Children's Hospital

Choose one: ☐ Akron Campus ☐ Mahoning Valley Campus

Address: One Perkins Square, Akron, OH 44308 — 6505 Market Street, Youngstown, OH 44512

Name/Dept: Center for Diabetes & Endocrinology Attention: _____

(330) 543-3276 (330) 543-8489 Endocrine@akronchildrens.org
Phone Fax Email Address

Release FROM

Release FROM the following Person(s) or Organizations:

Name: /School _____ Phone

_____ _____ _____ _____
Street Address City State Zip Fax

Purpose

Person/Place requesting records (check all that apply):

☐ Patient/Parent/Legal Guardian ☐ Doctor/Hospital ☐Lawyer ☐ Insurance Company ☐ Other _____

Purpose of Release (check all that apply):

☒ Patient Care ☐ Disability ☐ Insurance ☒ School ☐ Legal ☐ Personal Use ☐ Other _____

Information to Release

Dates of Treatment Requested: _____

☐ **Medical Record Abstract** – pertinent information generally used for continued care/personal use/disability.

The following items are included in a Medical Record Abstract:

After Visit/Discharge Summary, Emergency Record
History & Physical, Inpatient Consult Report(s)
Operative Report(s), Outpatient Clinic Note(s)
Radiology Reports, Lab or Other Tests

Other Information Requested (choose any to release):

☐ Vaccination (shot) records
☐ Radiology Reports
☐ Radiology Images on disc
☐ Lab results (blood work)
☐ Pathology Report
☐ Billing Records
☐ Appointment list
☒ Demographics page

☐ **Doctor's Office Reports** (Doctor or Department Name) _____

☒ **Other**: (please list exact documents) Any Treatment by School Personnel

Patient/Parent/Legal Guardian

This authorization expires **one year** from the date of signature, OR on this date / event: _____

I understand that treatment does not depend on me signing this Authorization. I understand that my/my child's/my ward's medical record might have information about sexually transmitted disease (STDs), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It might also have information about mental health problems or services, and/or treatment for alcohol or drug abuse. I understand that if I release records to someone other than a doctor, insurance company, hospital or other health-related organization, these records may no longer be protected by the Federal privacy regulations, and this person or organization might release the records to someone else, except as prohibited by 42 CFR Part 2 or other applicable law. I understand that I can revoke or cancel this Authorization at any time, but this does not apply to records that were already released. If I want to revoke it, I must notify the Privacy Officer, in writing, at Akron Children's Hospital, One Perkins Square, Akron, OH 44308.

By signing below, I affirm that I am the patient and/or the patient's personal representative, and have the authority to authorize who may access or receive the patient's health information.

Print for signature

_____ _____ _____ _____ _____
Signature of Patient or Parent/Legal Guardian **Printed Name** **Date**

My relationship to the patient is ☐ Self ☐ Parent ☐ Legal Guardian – Attach Court Order to show your authority to sign

_____ _____
Signature of Witness **Printed Name** **Date**

Akron Children's Hospital

HIPAA AUTHORIZATION to RELEASE MEDICAL RECORDS (FROM Children's)

Please PRINT and fill out entirely.

MRN

_____

Facility Use Only

Patient Information

Patient Name: _____
Last First Middle (any previous name) Date of Birth

_____
Patient Street Address City State Zip Phone

Release To

Release Information TO the following Person(s) or Organizations:

Name/Organization: /School /School Attention: _____

_____
Address City State Zip

_____ _____ _____
Phone Fax Email Address

Purpose

Person/Place requesting records (check all that apply):
☒ Patient/Parent/Legal Guardian ☐ Doctor/Hospital ☐Lawyer ☐ Insurance Company ☐ Other _____

Purpose of Release (check all that apply):
☒ Patient Care ☐ Disability ☐ Insurance ☒ School ☐ Legal ☐ Personal Use ☐ Other _____

Method of Release

Format of records to be released:
☒ on paper ☒ PDF [on CD or Jump Drive (if available)] ☒ Verbal communication only with person or agency listed above

Information May Be Sent Via: (*Note: Radiology images can only be placed on CD and mailed or picked-up)*
☒ Mail Delivery ☒ Fax ☒ Pick Up ☒ Encrypted Email* ☒ to MyChart* (*electronic records only, size restrictions apply)

Information to Release

Dates of Treatment Requested: _____ (If not specified, the **LAST 6 MONTHS** will be released)

☒ **Medical Record Abstract** – pertinent information generally used for continued care/personal use/disability.
The following items are included in a Medical Record Abstract:
After Visit/Discharge Summary, Emergency Record
History & Physical, Inpatient Consult Report(s)
Operative Report(s), Radiology Reports,
Lab or Other Tests

Other Information Requested (choose any to release):
☐ Vaccination (shot) records ☐ Billing Records
☐ Radiology Reports ☐ Appointment list
☐ Radiology Images on disc ☒ Demographics page
☐ Lab results (blood work)
☐ Pathology Report
☐ ACHP Records (specify ACHP): _____

☒ **Doctor's Office Reports** (Doctor or Department Name) Center for Diabetes & Endocrinology

☒ **Other**: (please list exact documents) AVS, School Form, Current Orders _____

Patient/Parent/Legal Guardian

This authorization expires **one year** from the date of signature, OR on this date / event: _____
I understand that treatment does not depend on me signing this Authorization. I understand that my/my child's/my ward's medical record might have information about sexually transmitted disease (STDs), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It might also have information about mental health problems or services, and/or treatment for alcohol or drug abuse. I understand that if I release records to someone other than a doctor, insurance company, hospital or other health-related organization, these records may no longer be protected by the Federal privacy regulations, and this person or organization might release the records to someone else, except as prohibited by 42 CFR Part 2 or other applicable law. I understand that I can revoke or cancel this Authorization at any time, but this does not apply to records that were already released. If I want to revoke it, I must notify the Privacy Officer, in writing, at Akron Children's Hospital, One Perkins Square, Akron, OH 44308.

By signing below, I affirm that I am the patient and/or the patient's personal representative, and have the authority to authorize who may access or receive the patient's health information.

_____ _____
Signature of Patient or Parent/Legal Guardian **Printed Name** **Date**
My relationship to the patient is ☐ Self ☐ Parent ☐ Legal Guardian – Attach Court Order to show your authority to sign

_____ _____
Signature of Witness **Printed Name** **Date**

Submit

Submit **completed form** AND a **copy of a valid Photo ID (if a current one is not on file with us)** to:

Mail form to:	**Fax** form to:		**Questions? Call**:
Akron Children's Hospital ENDOCRINOLOGY One Perkins Square Akron, OH 44308	330-543-8489		330-543-3276

Rev. 7/2019