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: Hematology/Oncology Attention: Team members

(330) 543-8581 (330) 543-3836 galtieri@akronchildrens.org
Phone Fax Email Address

Release FROM

Release FROM the following Person(s) or Organizations: **Parent/Guardian**

Name: _____ Phone

_____
Street Address City State Zip Fax

Purpose

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

Purpose of Release (check all that apply):
☐ Patient Care ☐ Disability ☐ Insurance ☐ Schoo ☐ Legal ☐ Personal Use ☑ Other PR; marketing, media, social media; education; Hem/Onc Celebration event

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) Photographs, video and names

Patient/Parent/Legal Guardian

This authorization expires **one year** from the date of signature, OR on this date / event: 5 years from date of signature or until age 18
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**

Photograph, Film or Vocal Recording Release

Akron Children's Hospital

One Perkins Square
Akron, Ohio 44308
330-543-1000

akronchildrens.org

Note: I authorize this release based on the following conditions:

- *These records become the property of Akron Children's or its representatives.*
- *This release is given without the promise of compensation.*
- *This release is effective until terminated by a retraction in writing from the person granting this authorization.*
- ***The parent/legal guardian and patient do release to** Akron Children's any right, title and/or interest of any kind they may have in the records produced.*

Release to photograph, film or record vocally for publicity purposes

I hereby grant to Akron Children's Hospital the right and authority to photograph, film and/or record vocally:

(Please print) *Patient's (or child's) name* _____ *Age*

These records may be used for promotional or publicity purposes and may be published in mass media publications, on the Akron Children's Hospital intranet, Internet or social media sites, or shown on **television or movie presentations.** The patient's and family's name may be used. This release is effective until revoked in writing by the undersigned. Such revocation shall only be effective to prevent any expanded future use of the records.

Signed (parent or legal guardian) _____ *Witness (for authorization by phone)* _____

Address _____ *Phone number* _____

Date _____