HIPAA AUTHORIZATION to RELEASE MEDICAL RECORDS

(**FROM** Children's)

Facility Use Only

MRN _____

PATIENT Name _____ Date of Birth _____
Last First MI

Address _____ Phone _____
Street City State Zip

Release TO the following Person(s) or Organizations:

Name:_____

Address: _____
Street City State Zip

Phone:_____ ***Fax:***_____

Person or Place that is requesting records:

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

Reason records are needed:

☐Patient Care ☐Disability ☐Insurance ☐School ☐Legal ☐Other _____

Release the records checked below, ☐verbally ☐on paper **or** ☐electronically (Cd or Jump Drive, if available) ☐to MyChart (if available. Parent/Legal Guardian needs to have MyChart Proxy access)

☐ Visit/Discharge summary ☐ Surgery report ☐ Pathology report
☐ Emergency room report ☐ Radiology reports (x-rays, MRI, CT scans) ☐ images on disc ☐ Billing records
☐ Vaccination (shot) records ☐ Doctor's office reports [Doctor or **Department** name_____]
☐ Lab results (blood work) ☐ Other _____
☐ Entire chart* - includes all hospital departments and ACHP records (physician notes, surgery reports, consults, OT/PT/Speech ancillary records, emergency room reports, discharge summaries, after visit summaries, immunization records, radiology reports, labs reports)

***Please note**: This can be hundreds or thousands of pages.

Treatment dates *(if not specified, **the LAST 6 MONTHS** will be released)*:_____

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.

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.

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

Print for signature

My relationship to the patient is:

☐Parent ☐ Legal Guardian * ☐Self ☐Other _____

***Attach Court Order to show your authority to sign.**

_____ _____ _____
Signature of Witness Printed Name Date