



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

MRN
_____ Facility Use Only

Please PRINT and fill out entirely.

Patient Information	Patient Name: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> Last First Middle (any previous name) Date of Birth </div> <hr/> Patient Street Address _____ City _____ State _____ Zip _____ Phone _____				
Release To	Release Information TO the following Person(s) or Organizations: Name/Organization: _____ Attention: _____ <hr/> Address _____ City _____ State _____ Zip _____ <hr/> Phone _____ Fax _____ Email Address _____				
Purpose	Person/Place requesting records (check all that apply): <input type="checkbox"/> Patient/Parent/Legal Guardian <input type="checkbox"/> Doctor/Hospital <input type="checkbox"/> Lawyer <input type="checkbox"/> Insurance Company <input type="checkbox"/> Other _____ Purpose of Release (check all that apply): <input type="checkbox"/> Patient Care <input type="checkbox"/> Disability <input type="checkbox"/> Insurance <input type="checkbox"/> School <input type="checkbox"/> Legal <input type="checkbox"/> Personal Use <input type="checkbox"/> Other _____				
Method of Release	Format of records to be released: <input type="checkbox"/> on paper <input type="checkbox"/> PDF [on CD or Jump Drive (if available)] <input type="checkbox"/> 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) <input type="checkbox"/> Mail Delivery <input type="checkbox"/> Fax <input type="checkbox"/> Pick Up <input type="checkbox"/> Encrypted Email* <input type="checkbox"/> 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) <input type="checkbox"/> 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 <input type="checkbox"/> Doctor's Office Reports (Doctor or Department Name) _____ <input type="checkbox"/> Other: (please list exact documents) _____ Other Information Requested (choose any to release): <input type="checkbox"/> Vaccination (shot) records <input type="checkbox"/> Billing Records <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Appointment list <input type="checkbox"/> Radiology Images on disc <input type="checkbox"/> Demographics page <input type="checkbox"/> Lab results (blood work) <input type="checkbox"/> Pathology Report <input type="checkbox"/> ACHP Records (specify ACHP): _____				
Patient/Parent/Legal Guardian	This authorization expires one year from the date of signature, <u>OR</u> 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. <div style="display: flex; justify-content: space-between;"> <div>Signature of Patient or Parent/Legal Guardian</div> <div>Printed Name</div> <div>Date</div> </div> My relationship to the patient is <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian – Attach Court Order to show your authority to sign <div style="display: flex; justify-content: space-between;"> <div>Signature of Witness</div> <div>Printed Name</div> <div>Date</div> </div>				
Submit	Submit completed form AND a copy of a valid Photo ID (if a current one is not on file with us) to: <table style="width: 100%; border: none;"> <tr> <td style="width: 25%; border: none;">Mail form to: Akron Children's Hospital One Perkins Sq., Akron, OH 44308 Attn: HIM</td> <td style="width: 25%; border: none;">Fax form to: 330-543-5360</td> <td style="width: 25%; border: none;">Email form to: records@akronchildrens.org</td> <td style="width: 25%; border: none;">Questions? Call: 330-543-8552</td> </tr> </table>	Mail form to: Akron Children's Hospital One Perkins Sq., Akron, OH 44308 Attn: HIM	Fax form to: 330-543-5360	Email form to: records@akronchildrens.org	Questions? Call: 330-543-8552
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Tips for Requesting Medical Record Copies – DID YOU KNOW?

- ✓ **Who Can Request Records:**
 - Patient (if 18 years of age or older, or a minor if the minor had authority to consent to their treatment)
 - Biological Mother
 - Biological Father married to biological mother at time of patient's birth
 - Under Ohio law, all other persons must provide documentation from the Court to show their authority to request records.
 - ✓ **What Records Should I Request?**
 - If the information requested is for continuing patient care, patient/parent/legal guardian use, or disability purposes the receiving entity generally only wants a **Medical Record Abstract** (see definition below) of pertinent information.
 - When requesting dates of service, a **Medical Record Abstract** of the medical records from the last 6 months of active treatment will be released, unless otherwise specified. If additional records are needed, please specify dates.
 - Requests for "**ALL**" information (which includes for example: progress notes, nurses notes, flowsheets, consent forms, etc.) can considerably delay processing of your request and become very costly. If you need assistance determining what to request, please ask the person/entity authorized to receive the information what they need, or contact a Health Information Management (HIM) Department representative at (330) 543-8552, and we will be happy to assist you.
- Medical Record Abstract** contains the following documentation:
- | | |
|---|---|
| Discharge Summary | From an Inpatient stay, this document is a summary of the care, treatment, services provided and progress toward established goals of an inpatient stay |
| Emergency Record | This record documents a summary of the care, treatment and services provided for a visit to the emergency room |
| History & Physical | This form details the present illness or care needs and denotes any relevant past history |
| Inpatient Consultation Report(s) | This report documents the findings of a physician asked to examine a patient during an inpatient or observation stay |
| Operative/Procedure Report(s) | This report details the surgeon/proceduralist's findings, technical procedures used, specimens removed and postoperative diagnosis |
| Outpatient Clinic Note(s) | Notes from outpatient office/therapy visits |
| X-Ray Reports, Labs or Other Tests | Radiology, lab results, and other tests including echocardiograms and EKG's |
- ✓ **Fees and Format:** Paper records sent to patient/parent/legal guardians or to providers for continuing patient care, are **not** charged. If you request a CD or if records are being sent to another person/entity, there may be a charge. See below:

Paper Copies	\$0.20/page, if not stored in electronic format. (There is a look up fee for paper copied records for third party requesters of \$18.93, then the \$0.20/page.)
CD	\$6.50 for patient/parents/guardians; \$10.00 for 3 rd party requesters. (Flat Fee, regardless of page count)
USB/Flash/Jump Drives	\$12.00 (Flat Fee, regardless of page count)
Radiology Images	\$20.00 for 1st CD, then \$4.00 for each additional CD.
Shipping/Handling	Actual Cost based on US Postal Service rates (waived if picked up)
 - * Fees are reviewed periodically and are based on state law (Ohio Revised Code 3701.742) and federal law (the HIPAA HITECH ACT).
 - If you did not specify records to be released on paper or CD, the records will be released on CD if 100 pages or more.
 - If you've selected "**Reviewed in HIM,**" an appointment needs to be scheduled. An HIM Department representative will contact you when the records are ready to be reviewed.
 - ✓ **How Long Will it Take?** The Health Insurance Portability and Accountability Act (HIPAA) allows healthcare providers **30 days to process records** requested by patients/parents/legal guardians. If we need more time to process your request, we can take another 30 days if we notify you that additional time is needed. Akron Children's Hospital strives to provide records more timely, however, occasionally the full 30 days are required.
 - ✓ **Can My Request be Denied?** Yes, some records may need to be reviewed prior to release and your request could be denied. Under federal and state law, Akron Children's Hospital may deny your request, in whole or in part, in limited circumstances. In the event Akron Children's Hospital denies your request, we must provide you with a written denial explaining why your request was denied.
 - ✓ **Can I Request Records Through MyChart?** Yes, if you request records through the patient's Akron Children's Hospital MyChart account, please note that only those records documented in the electronic medical record system can be sent through MyChart. Also, Radiology images cannot be sent through MyChart. Radiology Images are placed on a CD and sent in the mail. Once the records are released by HIM to MyChart, they are available to be viewed, downloaded, or printed for 2 months (60 days).
 - ✓ **How Do I Request Medical Records?** To request medical records, you must complete a **HIPAA Authorization to Release Medical Records Form**. This form may be found on our website: www.akronchildrens.org/records. The bottom of the form details different ways to submit the Request for Information. When you submit this form, you must also submit any documentation that is required to show your authority to request records (see "Who Can Request Records" above). If documentation is required, your request cannot be processed if you do not submit documentation of your authority to request records.