



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

MRN

Please fill out completely.

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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 <u>TO</u> the following Person(s) or Organizations:			
	Name/Organization: _____ Attention: _____			
	Address _____ City _____ State _____ Zip _____ 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) <input type="checkbox"/> Mail Delivery <input type="checkbox"/> Fax <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 Report(s), Lab or other Test(s)		Other Information Requested (choose any to release): <input type="checkbox"/> Lab/Pathology Reports <input type="checkbox"/> Billing Records <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Appointment list <input type="checkbox"/> Radiology imaging on CD <input type="checkbox"/> Demographic page <input type="checkbox"/> Vaccination (shot) records <input type="checkbox"/> Other imaging (specify): _____	
	<input type="checkbox"/> Doctor's Office Reports (Doctor or Department Name): _____			
	<input type="checkbox"/> Other (please list exact documents): _____			
Patient/Parent/Legal Guardian	This authorization expires <u>one year</u> 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.			
	Mandatory My relationship to the patient is: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian-if this box is checked, you must attach Court Order to show your authority to sign*			
Submit	Signature of Patient or Parent/Legal Guardian _____ Printed Name _____ Date _____			
	Signature of Witness _____ Printed Name _____ Date _____			
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: Akron Children's Hospital- Attn: HIM One Perkins Sq., Akron, OH 44308	Fax form to: 330-543-5360	Email form to: records@akronchildrens.org	Questions? Call: 330-543-8552	