Akron Children's Hospital

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

Please fill out completely.

FREE DOWNLOAD to Sign with Adobe Reader — Get Adobe® Reader®

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: Akron Children's 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 Marketing, public relations, social media

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)*

☐ Mail Delivery ☐ Fax ☒ 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 Report(s), Lab or other Test(s)

Other Information Requested (choose any to release):

☐ Lab/Pathology Reports ☐ Billing Records
☐ Radiology Reports ☐ Appointment list
☐ Radiology imaging on CD ☐ Demographic page
☐ Vaccination (shot) records
☐ Other imaging (specify): _____

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

☒ **Other** (please list exact documents): photos, videos, patient and family names, diagnosis and treatment information

Patient/Parent/Legal Guardian

This authorization expires five years from the date of signature, OR on this date / event: On patient's 18th birthday

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: ☐ Self ☐ Parent ☐ **Legal Guardian-if this box is checked, you must attach Court Order to show your authority to sign***

_____ _____ _____

Signature of Patient or Parent/Legal Guardian Printed Name Date

_____ _____ _____

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:	**Email** form to:	**Questions? Call**:
Akron Children's Hospital- Attn: HIM One Perkins Sq., Akron, OH 44308	330-543-5360	records@akronchildrens.org	330-543-8552

PRINT to Sign SAVE Form CLEAR Form

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

Tips for completion:
The hospital address must completed for the campus where the patient is treated.
Akron: One Perkins Square Akron OH 44308 Beeghly: 6505 Market Street Boardman, OH 44512
Method of release: We use encrypted email for photos, video and patient stories to protect privacy.
We ask for an extended, 5-year release in the event we would want to do a follow-up story. If past that deadline, or the patient turns 18 during that time, we will ask for another signed release.

PRINT to Sign SAVE Form