



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

MRN
Facility Use Only

Please PRINT and fill out entirely.

Form sections: Patient Information, Release TO, Release FROM, Purpose, Information to Release, Patient/Parent/Legal Guardian. Includes fields for name, address, phone, and checkboxes for release options.

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