



March 10, 2026

Dear Parent(s) or Guardians:

Plans are now underway for our 41st Annual Camp Ed Bear summer camping weekend!

This year's camp will be held on May 29-Sunday, May 31.

**Camp Ho Mita Koda (Welcome My Friend)**  
**14040 Auburn Road**  
**Newbury, Ohio 44065**

**Our camp theme will be: TBD**

Enclosed you will find the following:

- An application form
- A consent for medical treatment/hospitalization form
- A medical history form
- A physician permission form
- A consent for photography form
- An activity permission form
- A parent's information sheet
- A suggested clothing and equipment list
- Directions to Camp Carl upon request

Patients ages **6 through 15** are eligible to attend. This eligibility includes patients that will be six years of age by **May 29, 2026**.

A suggested donation for attending Camp Ed Bear is \$20. Contributions are welcome.

**On May 29th, camp registration will take place at Camp Ho Mita Koda.** All parents and campers will meet at Camp Ho Mita Koda. Your registration time will come with your cabin assignment in a future letter. Parents and siblings are invited to Camp Ed Bear on **Sunday, May 31**, for a departing ceremony at **10:30 a.m.**

**Parents are responsible for transporting their child to and from Camp Ho Mita Koda.**



**Please return:**

- Medical History Form
- All consent/permission form
- Parent and camper information sheets

**To:**

**Akron Children's Hospital  
One Perkins Square  
Akron, Ohio 44308  
Attn: Jen Heeter or Doug Palmer by May 8, 2026**

If more than one child will be attending Camp Ed Bear, please fill out separate applications.

Your Hematology/Oncology clinic doctor **REQUIRES** all campers be examined at least on a yearly basis. This means all campers must have been seen by their hematologist/oncologist between **June 1, 2025, and May 16, 2026**. All campers need to have a physical with their hematologist/oncologist prior to camp. If you need an appointment, please schedule as soon as possible by calling (330) 543-8581.

**No patients will be seen the week of camp for these appointments.**

Since our applications are now online, we have also added new consent forms. Please take your time to complete the application in full, as we need to have this information filled out before your camper can attend camp. The web address to get the application is [www.akronchildrens.org/campedbear](http://www.akronchildrens.org/campedbear). You can also send completed applications to [campedbear2020@akronchildrens.org](mailto:campedbear2020@akronchildrens.org) OR you can mail it to the address above.

If you have any questions regarding Camp Ed Bear, please feel free to contact us at **330-543-3108**.

We hope your child can join us for a great weekend at Camp Ed Bear!

From,

The Hematology-Oncology Staff & Doug Palmer, MSW, LSW

**PLEASE KEEP THIS LETTER**



**CAMP ED BEAR APPLICATION**

**CAMPER'S NAME** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

**CITY/STATE** \_\_\_\_\_ **ZIP** \_\_\_\_\_

**AREA CODE/TELEPHONE** \_\_\_\_\_ **SEX** \_\_\_\_\_

**BIRTHDATE** \_\_\_\_\_ **AGE AT TIME OF CAMP** \_\_\_\_\_

**T-SHIRT SIZE** \_\_\_\_\_

**HOW MANY YEARS HAS YOUR CHILD ATTENDED CAMP ED BEAR** \_\_\_\_\_

**PARENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

\*\*\*\*\*

A suggested donation for Camp Ed Bear is \$20.00 per camper. This fee is not required for attendance.

Payments may be made by cash, check or money order. Checks and money orders should be made payable to Camp Ed Bear.

\*\*\*\*\*

**APPLICATION PACKETS MUST BE RETURNED BY FRIDAY, May 8, 2026**

Please return application AND payment to:

**ATTN: Jen Heeter, Hematology/Oncology  
Akron Children's Hospital  
One Perkins Square  
Akron, OH 44308**



## CAMP ED BEAR

### SUGGESTED CLOTHING AND EQUIPMENT LIST

**All clothing and personal items must be labeled with the camper's name. We are not responsible for lost clothing. Please don't send good clothing to camp.**

- Sleeping bag or bed linen (including flat sheet and 1-2 blankets)
- Pillow
- 1 pair of jeans or slacks (Needed for horseback riding)**
- 2-3 pairs of short pants or cut-offs
- 2-3 shirts, including one with LONG SLEEVES
- 3-4 sets of underclothes
- 2-3 pairs of socks
- Pajamas, including bathrobe or cover-up
- 1 pair of sneakers
- 1 pair close-toed shoes (Needed for horseback riding)**
- sweater, sweatshirt or lightweight jacket
- rain poncho or lightweight raincoat
- swimsuit and beach towel
- flip-flops
- plastic bag for wet articles
- laundry bag for dirty clothes
- sunscreen
- Medication (in original container)

#### TOILET ARTICLES:

- Toothbrush
- Toothpaste
- Comb/Brush
- Shampoo
- Bath towel
- Washcloth
- Deodorant

#### OPTIONAL:

- Flashlight
- Sandals
- Hand soap in plastic container
- Sunglasses
- Hat, cap, visor, or scarf
- Mosquito repellent

If there are any questions concerning the suggested clothing list, please contact Doug Palmer at (330) 543-3108.

**PLEASE KEEP THIS LIST**



## CAMP ED BEAR

### CAMPER INFORMATION SHEET

Dear Parent(s)/Guardian (s):

For us to assist your child in adjusting to camp life, we are requesting the following information. All answers are strictly confidential. Please answer these questions as completely as possible. It is very important that the parent, rather than the child, complete this form.

CAMPER'S NAME: \_\_\_\_\_

Has he/she been to Camp Ed Bear? \_\_\_\_\_ When? \_\_\_\_\_

Is he/she experienced at being away from home at night? Yes \_\_\_\_\_ No \_\_\_\_\_

**Has he/she ever slept in a bunk bed?**

If yes, was it the top bunk or bottom bunk? \_\_\_\_\_

Does your camper experience: (please check)

- Bedwetting
- Fainting
- Tiring easily
- Nightmares
- Sleepwalking
- Constipation
- Food sensitivities/ allergies

Any others, please list:

Appetite:  Poor  Fair  Good

Swimming skill:  Can swim only with life jacket  
 Can swim only in shallow water  
 Can swim independently

Comments: \_\_\_\_\_

**All campers are required to take a swim test at the beginning of camp and swimming will be dependent on weather and water temperature.**



March 10, 2026

Dear Parent(s) or Guardians:

Summer camp can be an exciting experience for most children! Perhaps you, as parents of children with hematology-oncology disorders, may feel more comfortable knowing something about the personnel and facilities available for the medical care of your child at camp.

There will be hematology-oncology nurse practitioners, pediatric residents, and pediatric nurses in attendance always during the weekend of Camp Ed Bear. Routine medications and treatments will be handled by these staff members. All camp personnel will be briefed on the special needs of our campers and emergency procedures. In the event of an emergency, the Geauga County Sheriff's Department **will be available to call for help and have camper transported to Children's Hospital if needed.** A hematology/oncology physician will be available by telephone during the camp weekend.

**ALL MEDICATION MUST BE IN THE ORIGINAL LABELED CONTAINER**

While it is certainly not the intention of the medical staff to keep your child at Camp if he/she becomes seriously ill, we do plan to be ready to handle most basic medical problems such as sore throats, sprains, strains, gastrointestinal disturbances, etc., so camp may be as pleasant as possible. The special needs of children currently on chemotherapy will be kept in mind. Children with hemophilia will be observed for bleeding joints or other bleeding problems and treated according to need. If a more serious medical problem arises, we will contact you and your child's doctor to arrange for safe transport to home or Children's Hospital depending on the situation and what the circumstances warrant. ***We must have a telephone number and/or alternative telephone number where the parents can be always reached!***

If you have any further questions regarding your child's medical care at Camp Ed Bear, please feel free to contact us at 330-543-8581.

We look forward to having your child at Camp Ed Bear for a fun and safe weekend!

Sincerely,

Bobbi Moser, RN  
Bridget Shea, RN  
Amelia Mosher, RN

**PLEASE KEEP THIS LETTER**



**CAMP ED BEAR**

**CONSENT FOR MEDICAL TREATMENT/HOSPITALIZATION**

I/We authorize the accompanying Registered Nurses from the Division of Hematology-Oncology

to render to \_\_\_\_\_  
(Camper's Name)

the following medications as needed:

as well as permission to give **(please check one or both)**

Tylenol And /or  Ibuprofen

and any emergency care required while at camp.

Additionally, I/we authorize Camp Ed Bear officials, physicians, nurses, or other personnel to admit the above-named camper to Akron Children's Hospital if it is determined that hospitalization is necessary. In such an instance, I understand that I will be notified as soon as possible.

I know and understand that I/we are financially responsible for the medical care and treatment rendered to the above-named camper if there is a charge for the medical services provided.

Parent's or Guardian's Signature

\_\_\_\_\_

Relationship to Camper:

Age of Camper:

Date:

Witness's Signature (Required)

\_\_\_\_\_

Date: \_\_\_\_\_



**CAMP ED BEAR**

**MEDICAL HISTORY FORM**

Date \_\_\_\_\_ Child's Name \_\_\_\_\_

Hem/Onc Diagnosis \_\_\_\_\_

Hem/Onc Physician \_\_\_\_\_

**Date of last hematology/oncology clinic visit:** \_\_\_\_\_

Is child aware of the diagnosis? Yes \_\_\_\_\_ No \_\_\_\_\_ Birthdate \_\_\_\_\_

Age at time of Camp \_\_\_\_\_ Sex \_\_\_\_\_ Weight \_\_\_\_\_

Home Address \_\_\_\_\_

Area Code/Telephone \_\_\_\_\_ Alternate Phone Number \_\_\_\_\_

Person, relationship, area code/telephone to contact in an emergency: \_\_\_\_\_

Allergies (drugs, food, insect bites, etc.) And type of reaction to allergies (swelling, breathing difficulty, vomiting) \_\_\_\_\_

Any dietary restrictions? \_\_\_\_\_

Other medical problems (asthma, hay fever, diabetes, etc.): \_\_\_\_\_

Date of most recent tetanus immunization \_\_\_\_\_

(Must be within the past ten (10) years)

Has your child had chickenpox? Yes \_\_\_\_\_ No \_\_\_\_\_

Has your child received the chickenpox vaccine (VZIG)? Yes \_\_\_\_\_ No \_\_\_\_\_ Date \_\_\_\_\_



List any activity restrictions or limitations (crutches, no swimming, no prolonged exposure to sunlight, must wear hat, no contact sports, bottom bunk only, etc.)

List all medications which your child will need to take at Camp Ed Bear. Please write the approximate time they take each medication. Please have your child bring all of their scheduled and as needed medications to camp.

MEDICATION	DOSE	MORNING	AFTERNOON	EVENING	BEDTIME
<b>Ex: Tylenol</b>	<b>325mg once a day</b>			<b>6:00 pm</b>	

All medications **MUST** be in their original containers with your child's name and administration instructions clearly shown on each medication container.

We will store/supervise/administer all medications while at Camp Ed Bear and return any unused medications when your child returns home.

Indicate any further information about your child's medical needs or other needs that you feel we should know e.g. sleepwalking, needs to take medication with food or after meals, etc.



**IT IS REQUIRED THAT ALL CAMPERS BE MEDICALLY EXAMINED ON A YEARLY BASIS BY THEIR CHILDREN'S HOSPITAL HEMATOLOGIST/ONCOLOGIST. THIS FORM WILL ONLY BE SIGNED IF YOUR CHILD HAS BEEN EXAMINED IN THE LAST YEAR.**

Child's Name \_\_\_\_\_

For primary Hematologist/Oncologist to complete:

I hereby give my permission for this patient to attend Camp Ed Bear I have also listed any specific instructions or limitations below my signature.

Physician's signature: \_\_\_\_\_

Date: \_\_\_\_\_

You can send this page in with the rest of the application, and we will be able to get eligible applications signed by your physician.



**CAMP ED BEAR**

**ACTIVITY PERMISSION FORM**

The staff of Camp Ed Bear have planned a full and active schedule for your child's weekend at Camp. The activities that will be offered include: swimming, rock wall, canoeing, archery, ropes courses and other athletic activities.

**PLEASE COMPLETE ONLY SECTION A OR B**

**Section A**

I give permission for \_\_\_\_\_ to participate in all scheduled  
(Camper's Name)  
activities while at Camp Ed Bear. I hereby release from liability and hold harmless Camp Ed Bear/Camp Ho Mita Koda employees and staff from all liability which might result from the above-named camper participating in scheduled activities while attending Camp Ed Bear.

**Section B**

I give permission for \_\_\_\_\_ to participate in all activities  
(Camper's Name)  
except \_\_\_\_\_  
while at Camp Ed Bear, I hereby release from liability and hold harmless Camp Ed Bear/Camp Ho Mita Koda employees and staff from all liability which might result from the above-named camper participating in scheduled activities while attending Camp Ed Bear.

Parent's or Guardian's Signature \_\_\_\_\_

Relationship to Camper:

Date:

\_\_\_\_\_  
Witness's Signature (Required)

Date:



**FACT SHEET  
CAMP ED BEAR  
(CHILDREN'S HEMATOLOGY-ONCOLOGY PATIENTS AND STAFF)**

**What is Camp Ed Bear?**

It is a summer camping weekend experience for children and adolescents diagnosed with leukemia, cancer (solid tumors), sickle-cell anemia, hemophilia, and other blood disorders, which are currently or have previously been treated in the Division of Hematology-Oncology at Akron Children's Hospital. It was founded by Cheryl Jones, M.S.S.A., and former Hematology-Oncology Social Worker and is presently directed by Doug Palmer, MSW, LSW, Maria Hartland LISW-S and Leah Mallinos, MSW, LSW, Hematology-Oncology Social Workers.

**When was the summer program started?**

The first camp, Camp C.H.O.P.S. (Children's Hospital Patients and Staff), was in 1982 and 16 children attended. The number of campers has continued to grow each year. Camp Ed Bear is always planned for the weekend after Memorial Day.

**Why this type of camp?**

Camp Ed Bear is a weekend camping experience that enables patient to have informal, fun interactions with their hospital caregivers and volunteers. Many of our volunteers have coped with similar chronic conditions and attended Camp Ed Bear (or C.H.O.P.S.) as children. The children meet other children who truly understand what it is like to live with a serious illness, develop friendships and have opportunities to give and receive hope from one another.

**What is the age requirement?**

Children ages 6 through 15 are invited to attend. The age requirement relates to the child's age as of May 30, 2025. Exceptions may be considered by Camp Director.

**Where is Camp Ed Bear held?**

In 1982, the camping program was held at Camp Ledgewood in Peninsula, Ohio. From 1983 to 1990, the weekends were held at Camp Y-Noah located in Clinton, Ohio. From 1991 to 2010, our camp was held at Camp Christopher in Bath, Ohio. Since 2011, our camp has been held at Camp Carl in Ravenna, Ohio. Recently (2025), we have now switched venues to Camp Ho Mita Koda in Newbury, Ohio, and look forward to having a long withstanding partnership with Camp Ho Mita Koda.

**What is the cost?**

The cost per camper is \$20. Financial aid is available if a family is unable to pay some, or all, of the \$20 fee.

**How is funding obtained?**

Funding for the camping weekends is solicited from private donations, community resources, and organizations interested in child health. Project Ed Bear has offered complete funding for Camp C.H.O.P.S. since 2006 and with Camp Ed Bear

**How are the volunteer staff recruited?**

Most are nurses, social workers, residents/interns, and other health care professionals employed at Akron Children's Hospital. Other camp counselors are survivors or people interested in helping at our camp. All work is on a volunteer basis, and everyone is screened prior to their acceptance as counselors. We are very fortunate that many former campers desire to become camp counselors. At age 16 and 17 years old, they can apply to become Counselors in Training. At present, at least one third of our counselors are former campers.

**What about medications?**

Medical coverage is provided by pediatric Hematology-Oncology nurses who are familiar with the children and their diagnosis. At least one physician and/or nurse is on staff during the weekend as well as having the hematologists on call during the entire weekend. Children in all stages of illness and treatment attend camp and continue to receive all the oral chemotherapy necessary for the management of their illness. The distribution of medications is supervised and maintained by designated nursing staff. All medication must be in the original container.

**What activities are provided at camp?**

Swimming, arts and crafts, hiking, canoeing, rock wall, sports, and a dance as well as low and high ropes course, Gaga ball, and other activity initiatives. Camp Ho Mita Koda will look to offer a therapeutic horseback riding program for future camps.

For further information about Camp Ed Bear, please contact Doug Palmer, Social Work Department, at 330-543-3108, or Jen Heeter in the Division of Hematology-Oncology at 330-543-5191. Donations and can be sent to:

**Akron Children's Hospital  
One Perkins Square  
Akron, Ohio 44308  
ATTN: Jen Heeter, Hematology/Oncology**

**PLEASE KEEP THIS FACT SHEET**

**Please call if you need hard copy directions to Camp Ho Mita Koda**



Please fill out completely.

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<b>Patient Information</b>	<b>Patient Name:</b> _____ / / Last First Middle (any previous name) Date of Birth _____ ( ) <b>Patient Street Address</b> City State Zip Phone
<b>Release TO</b>	<b>Release Information TO Akron Children's Hospital</b> Choose one: <input type="checkbox"/> Akron Campus <input type="checkbox"/> Mahoning Valley Campus Address: <u>One Perkins Square, Akron, OH 44308</u> <u>6505 Market Street, Youngstown, OH 44512</u> Name/Dept: _____ Attention: _____ ( ) ( ) _____ Phone Fax Email Address
<b>Release FROM</b>	<b>Release FROM the following Person(s) or Organizations:</b> Name: _____ ( ) Phone _____ ( ) Street Address City State Zip Fax
<b>Purpose</b>	<b>Person/Place requesting records (check all that apply):</b> <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 _____ <b>Purpose of Release (check all that apply):</b> <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 _____
<b>Information to Release</b>	<b>Dates of Treatment Requested:</b> _____ <input type="checkbox"/> <b>Medical Record Abstract</b> – pertinent information generally used for continued care/personal use/disability. <b>The following items are included in a Medical Record Abstract:</b> After Visit/Discharge Summary, Emergency Record History & Physical, Inpatient Consult Report(s) Operative Report(s), Radiology Reports, Lab or Other Tests <input type="checkbox"/> <b>Doctor's Office Reports</b> (Doctor or Department Name) _____ <input type="checkbox"/> <b>Other:</b> (please list exact documents) _____ <b>Other Information Requested (choose any to release):</b> <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
<b>Patient/Parent/Legal Guardian</b>	This authorization expires <b>one year</b> from the date of signature, <b>OR</b> 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. _____ / / <b>Signature of Patient or Parent/Legal Guardian</b> <b>Printed Name</b> <b>Date</b> My relationship to the patient is <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian – Attach <u>Court Order</u> to show your authority to sign _____ / / <b>Signature of Witness</b> <b>Printed Name</b> <b>Date</b>



# PUBLIC RELATIONS CONSENT TO PHOTOGRAPH OR VIDEOTAPE

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## Photograph, Film or Vocal Recording Release

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 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.

---

Printed Name of Parent/Guardian and Relationship Signature of Parent/Guardian (If patient is less than 18 years.) Date Time

---

Address City State Zip Code

Phone Number

---

Printed Name of Witness to Signature Signature of Witness Date Time





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

MRN

Please fill out completely.

FREE DOWNLOAD to Sign with Adobe Reader



Facility Use Only

<b>Patient Information</b>	<b>Patient Name:</b> _____ <div style="display: flex; justify-content: space-between; font-size: small;"> <span>Last</span> <span>First</span> <span>Middle</span> <span>(any previous name)</span> <span>Date of Birth</span> </div> <hr/> <b>Patient</b> Street Address _____ City _____ State _____ Zip _____ Phone _____				
<b>Release To</b>	<b>Release Information <u>TO</u> the following Person(s) or Organizations:</b> Name/Organization: _____ Attention: _____ <hr/> Address _____ City _____ State _____ Zip _____ <hr/> Phone _____ Fax _____ Email Address _____				
<b>Purpose</b>	<b>Person/Place requesting records (check all that apply):</b> <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 _____  <b>Purpose of Release (check all that apply):</b> <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 _____				
<b>Method of Release</b>	<b>Format of records to be released:</b> <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 <b>Information May Be Sent Via:</b> (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)				
<b>Information to Release</b>	<b>Dates of Treatment Requested:</b> _____ (If not specified, the <b>LAST 6 MONTHS</b> will be released) <input type="checkbox"/> <b>Medical Record Abstract</b> – pertinent information generally used for continued care/personal use/disability. <b>The following items are included in a Medical Record Abstract:</b> After Visit/Discharge Summary, Emergency Record, History & Physical, Inpatient Consult Report(s), Operative Report(s), Radiology Report(s), Lab or other Test(s)  <input type="checkbox"/> <b>Doctor's Office Reports</b> (Doctor or Department Name): _____ <input type="checkbox"/> <b>Other</b> (please list exact documents): _____  <b>Other Information Requested (choose any to release):</b> <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): _____				
<b>Patient/Parent/Legal Guardian</b>	<b>This authorization expires <u>one year</u> from the date of signature, <u>OR</u> on this date / event:</b> _____ 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.  <b>*Mandatory*</b> 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*  Signature of Patient or Parent/Legal Guardian _____ Printed Name _____ Date _____  Signature of Witness _____ Printed Name _____ Date _____				
<b>Submit</b>	Submit <b>completed form</b> AND a <b>copy of a valid Photo ID</b> (if a current one is not on file with us) to: <table border="1" style="width:100%; border-collapse: collapse; font-size: small;"> <tr> <td style="width: 25%;"><b>Mail</b> form to: Akron Children's Hospital- Attn: HIM One Perkins Sq., Akron, OH 44308</td> <td style="width: 25%;"><b>Fax</b> form to: 330-543-5360</td> <td style="width: 25%;"><b>Email</b> form to: <a href="mailto:records@akronchildrens.org">records@akronchildrens.org</a></td> <td style="width: 25%;"><b>Questions? Call:</b> 330-543-8552</td> </tr> </table>	<b>Mail</b> form to: Akron Children's Hospital- Attn: HIM One Perkins Sq., Akron, OH 44308	<b>Fax</b> form to: 330-543-5360	<b>Email</b> form to: <a href="mailto:records@akronchildrens.org">records@akronchildrens.org</a>	<b>Questions? Call:</b> 330-543-8552
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