Cincinnati Children's
changing the outcome together

Authorization for Use and/or Disclosure of Protected Health Information (PHI)

Medical Record #: _____ CSN / ACCT #: _____ *(completed by CCHMC)*

This form authorizes Cincinnati Children's Hospital Medical Center (CCHMC) to use and/or disclose protected health information as described below. This is voluntary. CCHMC will not condition treatment, payment, enrollment, or eligibility for benefits based on this Authorization. The information used or disclosed due to this Authorization may be subject to re-disclosure and may no longer be protected by federal privacy regulations. See the back of this form for tips for requesting medical record copies.

NOTE: ***To avoid delays, complete all sections in full, then sign, date, and submit to one of the options below.***

Patient Information

Patient Name: _____
Last First Middle Maiden (if applicable)

Date of Birth: _____ Phone: (_____) _____

Name of Patient/Parent/Legal Guardian completing form: _____

Patient/Parent/Legal Guardian Email Address: _____

Patient/Parent/Legal Guardian Address: _____

Release To

Name: _____ Organization (if applicable): _____

Street Address: _____

City/State: _____ ZIP Code: _____ Phone: (_____) _____

Email: _____

Information to Release

Dates of Treatment Requested: The last one (1) year of active treatment will be provided unless specified. Dates: _____

➡ ☐ **Medical Record Abstract**

(Includes: Discharge Summaries, Emergency Records, History & Physicals, Inpatient Consultation Reports, Operative/Procedure Reports, Outpatient Clinic Notes, Radiology Reports, Labs and Other tests.)

If **NOT** requesting a Medical Record Abstract, specify the information below to be released:

☐ Discharge Summary	☐ Radiology Reports	☐ Operative Reports
☐ History & Physical	☐ Radiology Images	☐ Lab Reports
☐ Inpatient Consult Reports	☐ Emergency Department Record	☐ Registration Sheets
☐ Other Tests	☐ Outpatient Clinic Notes	☐ Immunizations

Specify Test, MD, Specialty, Clinic, etc.: _____

☐ Other: _____

_____

Purpose: *(Please select all that apply)*

☐ Medical Care, appointment date: _____

☐ Attorney/Legal	☐ Personal
☐ Insurance	☐ Disability/SSI
☐ Education	☐ Military

☐ Other: _____

Information May Be Sent By: *(Please select only one)*

☐ US Mail ☐ Emailed ☐ MyChart (released to Patient/Parent/Legal Guardian **only**)

Select format if choosing US Mail (select **one**): ☐ Paper ☐ CD

☐ Verbal communication between CCHMC care providers and person/entity named above. (HIM Department does not release PHI over the phone)

Parent / Patient / Legal Guardian

This Authorization will expire ☐ upon completion of this request *(default)*, ☐ one (1) year from the date signed, or ☐ on the following date or event (optional): _____. Authorized recipients may make multiple requests for authorized records until expiration. This Authorization may be revoked at any time. The revocation will not apply to uses or disclosures occurring before the receipt of your revocation request. To revoke this Authorization, the patient/parent/legal guardian must submit a revocation request in writing to the HIM department at the address below. Unless otherwise indicated above, this authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, and/or psychiatric/psychological conditions to the above-mentioned entity. See next page regarding restricted information. CCHMC will provide you with a copy of this Authorization upon request.

I, the undersigned, hereby authorize CCHMC to use and/or disclose information from the medical or financial record as specified above. Changes to authorized records or recipients will require a new Authorization form.

Signature of ☐ Patient ☐ Parent ☐ Legal Guardian ☐ GAL/CASA (required): _____

Note: Patient must sign if 18 years of age or older OR is an emancipated minor. If Legal Guardian or GAL/CASA is checked, documentation of the relationship must be provided.

Date: _____

Submit

Mail the completed form via US Mail to:	**Fax the form to:**	**Email the form to:**
Cincinnati Children's Hospital Medical Center 3333 Burnet Avenue, ML 5015 Cincinnati, Ohio 45229-3039	(513) 636-6729	ROI@cchmc.org

Request has been filled: ☐ Yes, Name _____ Date _____ Page Count _____

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Tips for Requesting Medical Record Copies

- ✓ Authorization forms signed by someone other than the Patient (if 18 years of age or older, or an emancipated minor*), or the patient's parent (if under the age of 18) **must** have a guardianship document signed by a Judge or Magistrate.

  ***Emancipated Minor:** (from ORC 2919.121) A minor shall be considered "emancipated" if the minor has married, entered the armed services of the United States, become employed and self-subsisting, or has otherwise become independent from the care and control of (his/)her parent, guardian, or custodian.

- ✓ Records will be released which are **not** subject to a permitted restriction under federal and state laws or an applicable confidentiality agreement.
- ✓ Requests for "**ALL**" information (which can include progress notes, nursing notes, flowsheets, consent forms, etc.) can considerably delay processing your request. If you need help determining what to request, please ask the person authorized to receive the information what they need. You can also contact a Health Information Management (HIM) Department representative at (513) 636-8233. We will be happy to assist you.
- ✓ When requesting dates of service, an Abstract (see definition below) of the medical records from the last one (1) year of active treatment will be released, unless otherwise specified. If additional records are needed, please specify dates.
- ✓ If the information requested is for continuing patient care, patient/parent/legal guardian use or disability purposes the receiving entity generally wants an **Abstract** of specific information.

Medical Record Abstract contains the following documentation:

- o Discharge Summary –this document is a summary of the care, treatment, services provided and progress toward goals of an inpatient stay
- o Emergency Record – this record documents a summary of the care, treatment and services provided for a visit to the emergency room
- o History & Physical – this form details the present illness or care needs and includes any relevant history
- o Inpatient Consultation Report(s) – this report documents the findings of a physician asked to examine a patient during an inpatient or observation stay
- o Operative/Procedure Report(s) – this report details the surgeon/proceduralist's findings, technical procedures used, specimens removed and postoperative diagnosis
- o Outpatient Clinic Note(s) – notes from outpatient office or therapy visits
- o X-Ray Reports, Labs or Other Tests – radiology, lab results, and other tests including echocardiograms and EKGs

- ✓ Records sent to patient/parent/legal guardians or to providers for continuing patient care, are **not** charged. If records are being sent to another person or entity, there may be a charge.

The person or entity identified to receive records will be sent a prepayment invoice once the total cost is determined.

Paper Copies/CD per page	First 10 pages $1.53/page, pages 11-50 $.79/page, 51 pages and up $.31/page (CD cost not to exceed $50 plus shipping and handling)
Radiology Images	$10.00 per study
Shipping/Handling	Actual cost based on US Postal Service rates

Fees are reviewed periodically. They are based on the State of Ohio ORC 3701.742 or the HIPAA HITECH ACT.

- ✓ The Health Insurance Portability and Accountability Act (HIPAA) allows healthcare providers **30 days to process records** requested by patients/parents/legal guardians with an acceptable extension period of 30 days when required. CCHMC strives to provide records quickly. Sometimes the full 60 days are required.
- ✓ If you need to review your records within the HIM Department, an appointment needs to be scheduled. Contact HIM at 513-636-4217. An HIM Department representative will contact you when the records are ready to be reviewed**.**
- ✓ If you are an attorney and submit a subpoena for medical records and you are not the prosecuting attorney requesting records for reasons of child abuse or neglect, please also submit the Authorization for use and/or Disclosure form signed by the patient/parent/legal guardian or a Court Order signed by a Judge or Magistrate.
- ✓ If records are requested to be picked up and are not picked up within 60 days the records will be destroyed.
- ✓ Records may be picked up by another individual, as indicated by the original requester, with proof of identification upon pick up.
- ✓ Please keep in mind that communications via email over the internet may not be secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed.
- ✓ For medical requests where in person pick up is needed, please email ROI@cchmc.org, to coordinate an appointment.