COCHLEAR IMPLANT (CI) EVALUATION PACKET

Thank you for your interest in allowing Cincinnati Children's Hospital Medical Center to help you though your child's cochlear implant journey!

Our center includes a team of providers specializing in hearing loss in kids. Their goal is to give your child the best care possible.

During your visit, you will receive information about ways to improve your child's communication skills and how a cochlear implant may help.

This packet includes information needed to start your child on his or her cochlear implant journey:

- ☐ The Cochlear Implant Journey Map
- ☐ Immunization Information Sheet
- ☐ Evaluation Intake Form *
- ☐ School and Intervention Form*
- ☐ Authorization for Use and/or Disclosure of Protected Health Information*
- ☐ Authorization for Use and/or Disclosure of PHI to School (if appropriate)*

(forms that must be completed and returned)*

Our team of providers are excited about beginning this journey alongside your family. If you have any questions along the way, please feel free to contact the program coordinator at (513) 636-4236 or email: auditoryimplantprogram@cchmc.org

COCHLEAR IMPLANT (CI) Evaluation Journey Map

Cincinnati Children's
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FAMILY'S TO DO LIST

CI TEAM'S TO DO LIST

REFERRAL

Family submits complete CI candidacy packet to audiologist and calls insurance company to see if cochlear implant is a covered benefit.

The Audiologist or ENT Provider submits referral to the CI team. CI Team sets up a patient care discussion meeting.

PACKET REVIEW MEETING

If family has not been contacted within 1 week after packet review date, family should contact the CI Team Admin (513) 636-3552.

CI Team reviews information and makes recommendations. A CI Team member contacts family to schedule evaluations within 7 days of meeting and mails evaluation plan to home address.

EVALUATIONS

Family attends all recommended appointments. If family has not been contacted to review next step within 2 week of completing evaluations, family should call CI Team Admin (513) 636-3552.

Upon completion of evaluations, the CI Team will meet to discuss their findings and determine if your child would benefit from a cochlear implant. A member of the team will reach out to family to discuss the team's recommendations.

INSURANCE/SCHEDULING

It is recommended that family contact their insurance company 3 weeks following evaluations to check pre certification status. Contact the following department by phone with questions:
Insurance Pre-certification (513) 636-4620
ENT Surgery Scheduling (513) 636-7218

ENT Insurance Pre-certification department submits request to insurance for coverage. This process can take up to 60 days. Once insurance approves surgery, a surgery date can be scheduled. CI team admin will call to schedule follow up appointments.

SURGERY/STIMULATION

Patient follows all pre-op guidelines and reports to outpatient surgery on scheduled date. Family attends all scheduled follow-up visits.

Required ENT visits
2 week Post Surgery Follow Up
Required Audiology visits
2 Week Post Surgery Stimulation
2 Week Post Stimulation MAPing
6 Week Post Stimulation MAPing
Post CI Auditory Function Evaluation

CONGRATUATIONS! Your child's hearing journey begins...

COCHLEAR IMPLANT(CI) Evaluation Journey Map

REFFERAL/CANDIDACY PACKET

All documents MUST be provided BEFORE any evaluations with the Cochlear Implant Team can be scheduled. The entire process, including evaluations and insurance pre-certification can take 3-6 months before surgery can be scheduled. Please return all information by ONE of the following ways:

EMAIL: auditoryimplantprogram@cchmc.org
FAX: (513) 636-7316 or 1 (800) 344-2443
MAIL: CI Team Program Coordinator
Cincinnati Children's Hospital Medical Center
333 Burnet Avenue MLC-2002, Cincinnati, OH 45229

Information needed from all Parents/Guardians:

_____ Insurance Card (copy of both sides)

_____ Ask your insurance carrier if cochlear implant is a "covered benefit"

_____ Cochlear Implant Evaluation Intake Form (included)
_____ Authorization of Use and/or Disclosure of Personal Health Information Form (included)
_____ Copy of Immunization Record (including record of Pneumovax or Prevnar). *Refer to attached Immunization information sheet*
_____ If you are not the child's custodial parent, we will need a copy of court verification of legal custody to determine who is allowed to make medical decisions for the child.

Information needed from your child's School/Early Interventionists/Therapists:

_____ Cochlear Implant School & Intervention Form (to be completed by teacher and/or EI representative) (included)
_____ Most recent IEP/MFE from school
_____ Most recent Outside Speech Therapy Notes/Test Scores/Reports
_____ Functional Listening Evaluation (if completed at school)

Additional information needed from your child's Hospital/Clinic (if not completed at Cincinnati Children's):

_____ Audiograms (hearing tests) and hearing aid visit reports
_____ Auditory Brainstem Response (ABR)
_____ CT/MRI scan on disk and report (if already completed)
_____ Other pertinent medical history reports

PACKET REVIEW MEETING

Once a complete packet is received the team will meeting the following Wednesday to review your child's case and to determine if additional evaluations are recommended. A member from the CI team will call to guide you through next steps in your child's journey.

EVALUATIONS

Your child may be scheduled to meet with several specialists on the Cochlear Implant Team. Please remember that your child must wear his/her hearing aids during all of the following evaluations:

_____ ***CI Consultation*** with a Cochlear Implant Audiologist to discuss the devices and their benefits and limitations. Additional hearing testing may also be completed.

_____ ***Speech Evaluation*** with a Speech-Language Pathologist to determine speech/language skills through appropriate testing and review of the provided documentation. A recommendation regarding therapy or additional services will be provided.

_____ ***Auditory Function Evaluation*** with an Aural Rehabilitation Audiologist to determine auditory skills through appropriate testing. A recommendation regarding therapy or additional services will be provided.

_____ ***Social Work Consultation*** to discuss and assess the expectations of the family (parents and child) regarding the projected benefit from a cochlear implant as well as assessing family structure and support as it affects decision-making and follow up.

_____ ***DDBP Assessment*** with a Developmental Pediatrician to evaluate your child to determine if other conditions may impact the development of speech and listening skills.

_____ ***ENT Follow Up*** with ENT Surgeon to discuss the medical and surgical aspects of cochlear implantation and to review the risks and benefits of the surgical procedure.

Once appointments are scheduled, a Cochlear Implant Evaluation Itinerary will be mailed to your home address to provide you with additional information regarding your upcoming visit.

INSURANCE/SCHEDULING

Upon completion of all recommended evaluations, the CI team will meet the following Wednesday to discuss evaluations and determine if your child is a good candidate for implantation. A member of the team will reach out to discuss next steps after this meeting. If the recommendation to move forward with implantation is made, a request for insurance approval is submitted. Once insurance approval is verified, (which could take up to 60 days) a surgery date can be set and post surgery appointments can be scheduled. You will receive phone calls for scheduling the following:

_____ ***Surgery Date***
_____ ***ENT Follow Up*** (2 weeks post surgery) with Surgeon to check the incision site and give medical clearance for stimulation of the implant.
_____ ***CI Stimulation*** (2 weeks post surgery) with CI Audiologist to activate device.
_____ ***CI MAPing*** (2 weeks post stimulation) with Audiologist adjust program settings.
_____ ***CI MAPing*** (4 weeks post stimulation) with Audiologist to adjust program settings.
_____ ***Auditory Function Evaluation*** (6 months post surgery) with an Aural Rehabilitation

STIMULATION

Congratulations! This is the first day your child may be able to hear with their implant! In reality, this is only one more step in your child's hearing journey as you look forward to many more appointments to improve hearing, listening and communication.

In preparation for this appointment please consider reviewing information on your child's device through the manufacturer's web site and any other resources the team has provided along the way.

Growing Through Knowing

Cincinnati Children's

Division of Audiology

Immunizations and Cochlear Implants

Frequently Asked Questions

What kinds of shots (immunizations) should my child have before getting a cochlear implant?

- Children getting a cochlear implant should have a set of shots to protect them from bacteria called Streptococcus pneumonia. A shot called Prevnar is given to young children. Older children are given a shot called Pnemovax23.

When should my child get these shots?

- Your child must have this shot before he/she can be scheduled for cochlear implant surgery.
- Prevnar should be given at 2 months, 4 months, 6 months and 12 months of age. If your child did not get his/her Prevnar dose at the suggested age, check with your doctor.
- Pneumovax should be given after the age of 2 years.

What if my child has not had any of these shots?

- Contact your child's doctor or local health department to set up an appointment.
- If your child is between 2 years old and 4 years 11 months, he/she will need to get a series of shots.
- If your child is 5 years or older, he/she only needs to get one shot.

Why are these shots important?

- Children who have a cochlear implant have a higher chance to get a type of meningitis (infection around the brain). These shots help your child's body fight off the types of bacteria that can cause this infection.

Where can I go for more information about these shots?

- The Centers for Disease Control has information about immunizations (shots) for people who have Cochlear Implants. Their website is: http://www.cdc.gov/vaccines/vpd-vac/mening/cochlear/dis-cochlear-gen.htm

Where can my child get these shots?

- Most pediatrician offices carry these shots. If your insurance does not cover well-child visits and shots, your local health department clinic can provide free shots for your child. Call the Cincinnati Department of Health at 513-352-2901 for clinic locations.

Be sure to include a copy of your child's Prevnar or Pneumovax vaccine when you return the Cochlear Implant packet to Cincinnati Children's Hospital.

Cincinnati Children's Hospital
Division of Audiology
Phone: 513.636.4236
Fax: 513.636.7316

KN-00192
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The Cochlear Implant Team

Cochlear Implant Evaluation Intake Form

Patient Name: _____

Date of Birth: _____

MRN: *(Office use only)* _____

Date: _____

Name of person completing this form: _____ Relationship to patient: _____

1. FAMILY INFORMATION

	Parent/Legal Guardian	Parent/Legal Guardian
Name:		
Date Of Birth:		
Address:		
City/State/ZIP code:		
Phone:		
Email:		
Occupation:		
Place of Employment:		

List names and ages of those who live in the household:	

Does this child have a foster parent or legal guardian? ☐ Yes ☐ No

If yes, is the foster parent/legal guardian a relative? ☐ Yes ☐ No

In order to better support your family as you investigate cochlear implantation, please complete the following:

Do you have any concerns with the following?	YES	NO		YES	NO
Reliable transportation	☐	☐	Family members agreeing with the decision to pursue a cochlear implant	☐	☐
Insurance coverage	☐	☐	Support in coping with your child's hearing loss	☐	☐
Finances	☐	☐	How your child will perform with a cochlear implant	☐	☐
Providing for your family	☐	☐	Types of available education or therapy support in your area	☐	☐
Employer's support for time off to attend appointments	☐	☐			

How would you describe the level of stress in your family? ☐ Unbearable ☐ High ☐ Average ☐ Low

What concerns you most about your child currently? _____

_____

Tell us what you hope a cochlear implant will do for your child? _____

_____

Please list your thoughts about what it takes to make cochlear implants successful? _____

_____

What do you think is a "poor" cochlear implant outcome? _____

_____

How long do you think it will take to receive benefit from the implant? _____

What do family and friends think about the implant? _____

_____

Patient Name: _____

Date of Birth: _____

MRN: *(Office use only)* _____

2. HEARING HISTORY

If **not** CCHMC, where was your child's hearing loss diagnosed?	
Other than CCHMC, where has your child's hearing been tested?	
When was your child's hearing loss diagnosed?	☐ Birth ☐ Later, list age: _____ ☐ Before talking ☐ After talking
Over time did your child's hearing loss:	☐ Stay the same ☐ Become worse
Is there a big difference in the amount of hearing loss between ears?	☐ Yes ☐ No
What caused your child's hearing loss? _____	

- **HEARING AIDS**

At what age did your child start wearing hearing aids?	☐ Birth – 6 months ☐ Later, list age: _____
How long has your child worn hearing aids?	☐ More than 3 months ☐ Less than 3 months
Does your child wear them during all waking hours, most of the time, or reject wearing them?	☐ Reject ☐ Wear them some of the time ☐ Wear them full time
Do hearing aids seem to help your child?	☐ Not really ☐ Can't tell ☐ Some ☐ A lot, but not enough
How important is it to you that your child wears his/her hearing devices during all waking hours?	☐ Very important ☐ Somewhat important ☐ Not that important
How far away can you be and your child still appears to hear you?	☐ 3 ft. (arm's length) ☐ 6 ft. (across table) ☐ 12 ft. (another room) ☐ unable to hear
Do hearing aids seem to help your child hear soft sounds (whispers)?	☐ Yes ☐ No
Does your child learn best by overhearing or by watching others?	☐ Overhearing ☐ Watching others
Do hearing aids help your child understand speech?	☐ Yes ☐ No

- **COCHLEAR IMPLANTS** *(Skip if not applicable)*

At what age did your child receive a cochlear implant?	☐ 12 months or less ☐ Later, list age: _____ ☐ Before talking ☐ After
How long has your child had the cochlear implant?	☐ More than 6 months ☐ Less than 6 months
Does your child wear a hearing aid in the opposite ear?	☐ Yes ☐ No
How long did it take to adjust the sound of the new device? Did anything help them adjust? _____	☐ Immediately ☐ Approximately a month ☐ By the third MAP ☐ 6 months
Does the cochlear implant seem to help your child?	☐ Uncertain ☐ Some, but not enough ☐ Significantly
How important is it to you that your child wears their hearing devices full time?	☐ Very important ☐ Somewhat important ☐ Not that important
Does the cochlear implant help your child hear distant sounds?	☐ Yes ☐ No
Does the cochlear implant help your child hear soft sounds (whispers)?	☐ Yes ☐ No
Does your child learn best by overhearing or by watching others?	☐ Overhearing ☐ Watching others
Does the cochlear implant help your child understand speech?	☐ Yes ☐ No

Patient Name: _____
Date of Birth: _____
MRN: *(Office use only)* _____

3. COMMUNICATION HISTORY

What do you feel is important to know about your child and how he/she communicates? _____

How does your child communicate with you and members of your family (i.e., speech, sign language, gestures)?

What are your communication goals for your child? _____

What communication intervention are you receiving at this time? _____

What goals are being addressed in intervention? _____

How involved are you or other family members in therapy sessions? _____

How do you incorporate therapy techniques at home? _____

4. SCHOOL HISTORY/EARLY INTERVENTION/THERAPIES

Is your child enrolled in:	
Early Intervention ☐ Yes ☐ No	Where/How often:
	Contact name/phone #:
Daycare ☐ Yes ☐ No	Where/How often:
	Contact name/phone #:
School ☐ Yes ☐ No ☐ Preschool ☐ Elementary School ☐ Middle School ☐ High School ☐ Home School	Where/How often:
	Contact name/phone #:
Private Speech Therapy ☐ Yes ☐ No	Where/How often:
	Contact name/phone #:
Private Occupational Therapy ☐ Yes ☐ No	Where/How often:
	Contact name/phone #:
Private Physical Therapy ☐ Yes ☐ No	Where/How often:
	Contact name/phone #:
Other: _____	Where/How often:
	Contact name/phone #:

Is your child mainstreamed with typical-hearing students? ☐ Yes ☐ No ☐ Unsure

Does your child have an interpreter in the classroom? ☐ Yes ☐ No ☐ Unsure

Does your child have an Individualized Education Plan (IEP) or 504? ☐ Yes ☐ No ☐ Unsure

Patient Name: _____

Date of Birth: _____

MRN: *(Office use only)* _____

5. MEDICAL HISTORY

Have any other family members had trouble with their hearing at a young age? ☐ Yes ☐ No

If so, please explain: _____

Does your child have any of the following developmental/medical conditions besides hearing loss, which may change their rehabilitation path with cochlear implants?

☐ Cytomegalovirus (CMV)	☐ Genetic disorder	☐ Meningitis
☐ Cerebral Palsy (CP)	☐ Autism	☐ Family history of migraines
☐ Down syndrome	☐ Hydrocephalus w/ shunt	☐ Heart problems
☐ Bleeding disorder	☐ Neurofibromatosis	☐ Cancer
☐ Immunosuppressed	☐ Cochlear malformation	☐ Brain abnormalities
☐ CHARGE syndrome	☐ Head noise/ringing in ears	☐ Balance/coordination problems

Did your child have any problems at birth or need to be hospitalized immediately following birth? ☐ Yes ☐ No

If so, please explain: _____

_____

Has your child had any significant illnesses that required hospitalization? ☐ Yes ☐ No

If so, please describe, including age of onset: _____

_____

Has your child ever had surgery? ☐ Yes ☐ No If so, at what age? _____

If so, what surgeries were completed? _____

_____

Did your child have a genetics work up? ☐ Yes ☐ No

If so, what were the results? _____

Did your child have a MRI or CT scan? ☐ Yes ☐ No

If so, what were the results? _____

IMMUNIZATION HISTORY:

If your child is between the ages of 0-2 years, has he/she completed the Prevnar® vaccine series?

☐ Yes If yes, please include a copy of the immunization records.

☐ No If no, your child needs this vaccine prior to Cochlear Implant surgery.

If your child is over the age of 2, has he/she received the Pneumovax® 23 vaccine?

☐ Yes If yes, please include a copy of the immunization records.

☐ No If no, your child needs this vaccine prior to Cochlear Implant surgery.

Office use only:

Form received by: _____

Signature/Credentials Printed Name Date/Time

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

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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 in the manner described below and is voluntary. CCHMC will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization. The information used or disclosed as a result of this Authorization may be subject to re-disclosure by the person or entity receiving such information, and no longer protected by the federal privacy regulations. Please see the back of this form for tips for requesting medical record copies.

NOTE: Failure to complete each section of this form in its entirety *(including dates needed) may significantly delay the processing of your request*.

Patient Information

Patient (Pt) Name: _____ Gender: ☐ Male ☐ Female
Last First Middle Maiden (if applicable)

Date of Birth: _____ Phone: ( ) _____

Name of Patient/Parent/Legal Guardian (LG) 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: _____ Telephone: ( ) _____

Information May Be Sent Via (*Note: Radiology images can only be placed on CD and mailed or picked-up***):**

☐ US Mail ☐ MyChart (released to Patient/Parent/Legal Guardian **only**) ☐ Picked Up (Individual to Pick-up): _____

☐ Reviewed in Health Information Management (HIM) (Appointment Necessary)

I would like copies provided in the following format: ☐ Paper- see fees on back of form ☐ CD- cost not to exceed $50 plus shipping and handling.

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

Purpose (Optional for Pt/Parent/LG)

Records are to be released for the following purpose(s): *(please select all that apply)*

☐ Medical Care, patient has an appointment on the following date: _____

☐ Attorney/Legal ☐ Personal ☐ Insurance ☐ Disability/SSI ☐ Education ☐ Military ☐ Other: _____

Information to Release

Dates of Treatment Requested: Last 2 years of active treatment will be provided unless specified. Dates: _____

☐ Medical Record Abstract – pertinent information generally used for continued care/personal use/disability. *(The following items are included in a Medical Record Abstract.)*

- ☐ Discharge Summary
- ☐ Emergency Department Record
- ☐ History & Physical
- ☐ Inpatient Consult Reports, Specify MD/Specialty: _____
- ☐ Outpatient Clinic Notes, Specify Clinic(s): _____
- ☐ Other Tests, please specify: _____
- ☐ Operative Reports
- ☐ Radiology Reports
- ☐ Lab Reports

Other Information Requested:

- ☐ Immunizations
- ☐ Radiology Images
- ☐ Registration Sheets
- ☐ Other: _____
- ☐ Other: _____

Patient/Parent/Legal Guardian

Unless otherwise revoked, this Authorization will expire one (1) year from the date signed or, if specified on the following date (optional): _____. Unless otherwise noted, records documented after the signature date below will be released upon verbal or written request of the Patient/Parent/Legal Guardian for up to one year from the date of signature. This Authorization may be revoked at any time. However, the revocation will not apply to uses or disclosures occurring prior to our receipt of your revocation request. To revoke the Authorization the patient/parent/legal guardian must submit a revocation request in writing to the HIM department at the address below. If CCHMC requests this Authorization for its own use or disclosure, a copy of this Authorization must be provided. Please refer to the CCHMC Notice of Privacy Practices.

I, the undersigned, hereby authorize CCHMC to use and/or disclose information from the medical or financial record as specified 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, alcoholism, and/or psychiatric/psychological conditions to the above mentioned entity.

Signature of Patient: _____ Date: _____
(if 18 years of age or older OR is an emancipated minor)

Signature of ☐ Parent ☐ Legal Guardian ☐ GAL/CASA: _____ Date: _____
Note: If Legal Guardian, GAL/CASA is checked, documentation establishing relationship must be provided, or on record, in order to comply with this request.

Submit

Verify that all sections are completed in full, signed and dated. Upon completion, please do one of the following:

Mail the completed form via US Mail to:
Cincinnati Children's Hospital Medical Center
3333 Burnet Avenue, ML 5015
Cincinnati, Ohio 45229-3039

Fax the Form to:
(513) 636-6729

E-mail the Form to:
him1@cchmc.org

Request Has Been Fulfilled: ☐ Yes, Name _____ Date _____ Page Count _____

Name: _____

DOB: _____

MRN: _____

Please make copies of this form to give to other professionals working with the child at your facility.

Please provide all written reports that include observations of auditory abilities and speech language test results.

Date: _____

Name of person completing form: _____ Title: _____

Phone number: _____ Email address: _____

Program name: _____

Program address: _____

_____

Describe the child's main mode of communication: _____

Is your school program? (*Check all that apply*) ☐ Oral ☐ Total Communication ☐ Manual (sign) ☐ Mainstream

What support services are offered to this child at your school or by your program? (*Check all that apply*)

☐ Educational audiologist
☐ Classroom aide
☐ Hearing itinerate teacher
☐ Interpreter
☐ Speech therapy
☐ Special education
☐ Other: _____

What accommodations are there for hearing loss? (*Check all that apply*)

☐ Preferential seating
☐ Captioning
☐ Modified assignments
☐ Pre-teaching
☐ Extended test time
☐ Note taker
☐ Resource room

Does the child wear any of the following? (*Check all that apply*)

☐ Hearing Aid
☐ Cochlear Implant (CI)
☐ FM system/remote microphone
☐ N/A

Describe the child's auditory progress with the current amplification: _____

_____

How much difference do you see when this child is wearing versus not wearing hearing devices?

☐ Very little difference ☐ Some difference ☐ Quite a difference

Does the child wear hearing devices consistently and without resistance during school/therapy? ☐ Yes ☐ No

If **NO**, please describe: _____

If this child **does not** recognize speech do they recognize speech patterns songs and phrases? ☐ Yes ☐ No ☐ N/A

How would you characterize this child's auditory learning style?
☐ Learns easily through casual listening
☐ Repetition and visual cues really help
☐ Dependent on visual cues and routine, to learn

Please select this child's ability to learn vocabulary:
☐ Rapidly learns new words through overhearing
☐ Needs to hear new words more often than others
☐ Poor, every word requires direct instruction

How does this child communicate with peers (i.e., speech, sign language, gestures)?

_____

<u>This section is to be completed by the Speech Language Pathologist:</u>

(Please enclose a copy of the IFSP, IEP / Multi-Factored Evaluation (MFE) and any additional speech and language test results)

Describe the child's speech and language abilities: _____

How many words does the child… Speak: _____ Sign: _____

How many words does the child understand? Spoken: _____ Sign: _____

What tests have been completed? (*Check all that apply*)

Birth-3:
- ☐ Rossetti Infant Toddler Language
- ☐ MacArthur Bates Communicative Development Inventories (Words and Gestures or Words and Sentences)

Preschool:
- ☐ Clinical Evaluation of Language Fundamentals – Preschool- age 2
- ☐ Goldman Fristoe Test of Articulation – 3

School age:
- ☐ Clinical Evaluation of Language Fundamentals – 5
- ☐ Goldman Fristoe Test of Articulation – 3

Describe any physical or cognitive disabilities impacting the child's progress: _____

Describe the child's attendance history: _____

Describe the parent's involvement: _____

Name: _____

DOB: _____

MRN: _____

Describe your impression of the child's and family's expectations of the cochlear implant: _____

Additional comments regarding the child and the cochlear evaluation process: _____

Signature of Person Completing Form | Printed Name | Date

Please return all documents by ONE of the following ways:

- **FAX**: 513-636-7316
- **Email**: AuditoryImplantProgram@cchmc.org
- **Mail**:

  Cincinnati Children's Hospital Medical Center
  Audiology/ ML 2002
  Attn: Auditory Implant Program Coordinator
  3333 Burnet Ave, Cincinnati, OH 45229

If you have any questions regarding this form, please contact the Auditory Implant Coordinator by calling 513-636-4236.

Authorization for Use and/or Disclosure Of Protected Health Information to Schools

MEDICAL RECORD #:_____

PATIENT INFORMATION (Please Print):

Last Name	First Name	Middle Initial	Maiden Name (if applicable)	Gender
Address	City	State	Zip Code	Phone Number
Date of Birth	Email Address (optional)			

Please check/specify the following type of information, including dates of treatment that you want to be disclosed pursuant to this Authorization. Failure to specify will render this Authorization invalid.

Dates of Treatment/Particular Illness/Admission Requested:_____

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Educational EvaluationS
- ☐ Speech and Language Evaluations
- ☐ Occupational Therapy/Physical Therapy Evaluations
- ☐ Hospital School Attendance
- ☐ School Recommendations
- ☐ Academic/Educational Information
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ ALL INPATIENT MEDICAL RECORDS (See Note)
- ☐ ALL OUTPATIENT MEDICAL RECORDS (See Note)

Purpose for Disclosure

☒ School

The purpose of the use and/or disclosure of this information is to best provide for the student's educational, physical and emotional adjustment between the hospital setting and the school setting.

Disclose Records To:	
Name	
School	
Title	
Street Address	
City, State, Zip	
Telephone Number	

Records may be:
- ☐ Mailed
- ☐ Reviewed only
- ☐ Faxed
- ☐ Picked up by Whom:_____
- ☐ In-Person Meeting
- ☐ Shared by Telephone

This Authorization will expire 1 year after the date below, or sooner by my choice, in which case, Authorization will expire on _____, or _____ (event) occurs. This Authorization may be revoked at any time to the extent that use and/or disclosure has not already occurred prior to your request for revocation. In order to revoke the Authorization the individual/parent/legal guardian must submit a revocation request in writing to the Health Information Management department, 636-8233. Please refer to Cincinnati Children's Hospital Medical Center's (CCHMC) Notice of Privacy Practices.

CCHMC will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization. The information used or disclosed as a result of this Authorization may be subject to redisclosure by the person or entity receiving such information, and thus no longer protected by the federal privacy regulations. I understand that a standardized fee has been established for copies of medical records. Please inquire regarding these fees prior to requesting copies.

I, the undersigned, hereby authorize Cincinnati Children's Hospital Medical Center to use and/or disclose information from my (or give relationship) _____ medical or financial record as specified 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, alcoholism, and/or psychiatric/psychological conditions to the above mentioned entity(s).

Signature: **Date:** ☐ **Patient** ☐ **Parent** ☐ **Legal Guardian**

The above statements must be signed and dated to be valid. If the patient is an emancipated minor or 18 years of age, he/she is required to sign the Authorization. If CCHMC requests this Authorization for its own use or disclosure, a copy of this Authorization must be provided to the individual completing this form.

Request Has Been Fulfilled: Yes, Initials _____ Date _____