

This form authorizes Cincinnati Children's Hospital Medical Center to use and/or disclose protected health information in the manner described below and is voluntary. Cincinnati Children's 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 no longer protected by the federal privacy regulations.



Please note that each section of the form must be completed in its entirety. Failure to specify (including dates) will delay the processing of your request.

Patient Information	<p>Patient Name: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <small style="display: inline-block; width: 150px; margin-left: 10px;">Last First Middle Maiden (if applicable)</small></p> <p>Date of Birth: _____ Phone: () _____</p> <p>Parent/Guardian/Requestor Completing Form: _____</p> <p>Requestor Email Address (optional): _____</p> <p><i>Note: Email addresses will be utilized strictly to facilitate the processing of your request. No protected health information will be conveyed in this manner.</i></p>
Release To	<p>Name: _____ Organization (if applicable): _____</p> <p>Street Address: _____</p> <p>City/State: _____ Zip Code: _____ Telephone: () _____</p> <p>Information May Be: <input type="checkbox"/> Mailed <input type="checkbox"/> Reviewed Only <input type="checkbox"/> Discussed via Telephone <input type="checkbox"/> In Person Meeting <input type="checkbox"/> Picked Up By: _____</p> <p>Requests greater than 500 pages will be provided in an electronic format saved to disc <u>unless specifically requested to be on paper</u>. For copy requests greater than 100 pages, the requestor may choose to receive the medical record on a disc at a 50% discount. If you would like the record provided in an electronic format, please indicate by checking one of the following: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
Purpose	<p>Records are to be released for the following purpose(s): <i>(Select all that apply)</i></p> <p><input type="checkbox"/> Medical Care <input type="checkbox"/> Attorney/Legal <input type="checkbox"/> Personal <input type="checkbox"/> Insurance <input type="checkbox"/> Disability/SSI <input type="checkbox"/> Other: _____</p>
Information to Release	<p> Dates of Treatment/Particular Illness/Admission Requested: _____</p> <p><input type="checkbox"/> Patient/Physician Abstract – pertinent information generally used for continued care/personal use. <i>(See the reverse of this form for information regarding what is included in a Patient/Physician Abstract.)</i></p> <p><input type="checkbox"/> Discharge Summary <input type="checkbox"/> Emergency Department Record <input type="checkbox"/> X-Ray Reports, Labs or Other Tests</p> <p><input type="checkbox"/> History & Physical <input type="checkbox"/> Immunizations <input type="checkbox"/> Consultation Reports, Specify MD: _____</p> <p><input type="checkbox"/> Operative Reports <input type="checkbox"/> Registration Sheets <input type="checkbox"/> Outpatient Clinic Notes, Specify Clinic(s): _____</p> <p><input type="checkbox"/> Other: _____ <i>Note: Psychotherapy notes must be requested through a separate authorization.</i></p>
Patient/Parent/Legal Guardian Authorization	<p>Unless otherwise revoked, this Authorization will expire one (1) year from the date it is signed or, if specified, on the following date, event or condition (complete if desired): _____ 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. In order to revoke the Authorization the individual/parent/legal guardian must submit a revocation request in writing to the Health Information Management department at the address below. Please refer to Cincinnati Children's Notice of Privacy Practices. If Cincinnati Children's requests this Authorization for its own use or disclosure, a copy of this Authorization must be provided to the individual completing this form.</p> <p>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).</p> <p>Signature of Patient: _____ Date: _____ <small>(if 18 years of age or older OR is an emancipated minor)</small></p> <p>Signature of <input type="checkbox"/> Parent/ <input type="checkbox"/> Legal Guardian (check one): _____ Date: _____ <small>Note: If Legal Guardian box is checked, documentation establishing guardianship must be provided or on record in order to comply with the above request.</small></p>
Submit	<p>Please verify that all sections are completed in full. Upon completion, please send the form to:</p> <p>Cincinnati Children's Hospital Medical Center OR Fax the form to: (513) 636-6729 3333 Burnet Avenue, ML 5015 Cincinnati, Ohio 45229-3039</p>



DID YOU KNOW?

Tips for Requesting Medical Record Copies

- ✓ **Did You Know:** If the information requested is for continuing patient care the receiving caregiver generally only wants an abstract of pertinent information. This same abstract usually meets the need for individual use.

This information is called a Patient/Physician Abstract and contains the following:

- Discharge Summary – this document is a summary of the care, treatment, services provided and progress toward established goals of an inpatient stay
 - Emergency Record – this record documents the care, treatment and services provided for a visit to the emergency room
 - History & Physical – this form details the present illness or care needs and denotes any relevant past history
 - Operative Report(s) – this report details the surgeon's findings, technical procedures used, specimens removed and postoperative diagnosis
 - Consultation Report(s) – this report documents the findings of a physician requested to examine a patient
 - X-Ray Reports, Labs or Other Tests
 - Clinic Note(s) – includes the initial assessment and most recent visit documentation
- ✓ **Did You Know:** There is a charge for medical record copies. **Requestors will be sent a prepayment invoice upon determination of total cost.** Note: This charge is waived for records sent directly to continuing care providers.

Basic Retrieval Fee	\$ 17.70/request (waived for patient requests)
Pages 1 – 10	\$ 1.17/pg
Pages 11 – 50	\$.60/pg
Pages 51 +	\$.24/pg
Microfilm/Microfiche	\$ 1.97/pg
Shipping/Handling	\$ Actual Cost (waived if picked up)

Fees are reviewed on an annual basis and are based on the State of Ohio Sub. HB 331.

- ✓ **Did You Know:** The Health Insurance Portability and Accountability Act (HIPAA) allows healthcare providers 30 days to process record requests with an acceptable extension period of 30 days when required. CCHMC strives to provide records more timely, however occasionally the full 30 days are required due to record availability (e.g. physician return, offsite storage return, etc).
- ✓ **Did You Know:** Requests for **all** information (including progress notes, consent forms, registration sheets, etc) can delay processing and become very costly. If you need assistance determining what to request, a Patient Information Coordinator (513)636-8233 will be happy to assist you.
- ✓ **Did You Know:** Requests for information signed by someone other than the patient's parent must be accompanied by guardianship documentation signed by a Judge or Magistrate.
- ✓ **Did You Know:** When requesting psychiatric records a separate psychotherapy authorization must be completed in addition to the general authorization.