



**AUTHORIZATION FOR USE and/or  
DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**My Care Connection Chronic Condition Portals**

**PATIENT INFORMATION (Please Print)**

**MEDICAL RECORD #:** \_\_\_\_\_

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

**I understand that the My Care Connection chronic condition patient portals include the following information about my care at Cincinnati Children's:**

- |  |  |
|--|--|
| <input type="checkbox"/> Most Recent List of Medications           | <input type="checkbox"/> X-Ray Reports or Other Tests                            |
| <input type="checkbox"/> Lab Results                               | <input type="checkbox"/> Surgery or Procedure Reports                            |
| <input type="checkbox"/> Registration Information                  | <input type="checkbox"/> Growth Charts   |
| <input type="checkbox"/> Posted Questions and Answers              | <input type="checkbox"/> Posted Documents  |
| <input type="checkbox"/> Posted Messages from Portal Administrator | <input type="checkbox"/> Visit Dates and Types                                   |
| <input type="checkbox"/> Scanned Copies of Release Forms           | (Includes Emergency Room visits, clinic appointments and stays                   |
| <input type="checkbox"/> Other _____                               | in the hospital. Information is <b>not</b> limited to condition-related visits.) |

**I want to authorize Cincinnati Children's to grant access to the person below to the My Care Connection chronic condition patient portal to see my health information.**

<b>Grant Portal Access To:</b>	
<b>Name</b>	
<b>Relationship to Patient</b>	
<b>Street Address</b>	
<b>City, State, Zip</b>	
<b>Telephone Number</b>	
<b>Email (optional)</b>	

This Authorization will expire 18 months after the date below, or sooner by my choice, in which case this Authorization will expire on \_\_\_\_\_ (insert date). This Authorization may be revoked at any time to the extent that use and/or disclosure has not already occurred prior to my request for revocation. In order to revoke the Authorization, the patient/parent/legal guardian must submit a revocation request in writing to the Health Information Management department, 513-636-8233. 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, the undersigned, hereby authorize Cincinnati Children's Hospital Medical Center to use and/or disclose information from my medical record, as specified above, by granting access to the person specified above to the My Care Connection chronic care patient portal. 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 person.

**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 \_\_\_\_\_

<b>For Portal Admin Use Only</b>		
<b>Portal User Name</b>	<b>Temporary Password</b>	<b>Date Account Established</b>