CONFIRMATION OF TREATMENT RELATIONSHIP AND REQUEST FOR PROTECTED HEALTH INFORMATION

This document confirms that the following Cincinnati Children's Hospital Medical Center patient, _____ [full name of patient], with a birth date of _____, is a patient of the physician/physician practice identified below. Our practice information is as follows:

This patient has an appointment date of: _____ **Time:** _____

Practice/Physician Name:

Practice Street Address:

City: **State:** **Zip Code:**

Telephone Number: **Secure Fax Number:**

Send requested information **to THE ATTENTION OF**:

We hereby request that CCHMC transmit to us the following patient information for our use in treating the patient:

Dates of treatment/Particular illness/Admission requested: _____

Information to be released: ☐ **Consult Report by Dr.** _____
☐ **Discharge Summary** ☐ **ED Record** ☐ **Immunizations** ☐ **Operative Report** ☐ **Outpatient Clinic Note**
☐ **Other:** _____

We understand that the information will be faxed to us at the secure fax number indicated above. Please contact the undersigned with any questions.

Printed Name of Person Completing this Form:

Signature*: **Date:**

***NOTE:** The completed form **must** be signed by the treating physician or designated authorized representative. **Forms will not be considered valid without signature and dates**.

For CCHMC HIM purposes only:
Medical Record #: _____ Request Has Been Fulfilled: ☐ Yes, Initials _____ Date: _____