

CONFIRMATION OF TREATMENT RELATIONSHIP AND REQUEST FOR PROTECTED HEALTH INFORMATION

This	document	confirms	that the following					
physi	cian/physicia	n practice ic	lentified below. Our pr				, 1	s a patient of the
This	patient has a	n appointn	nent date of:			Time:		_
Pract	tice/Physicia	n Name:						
Pract	tice Street A	ddress:						
City:			State:			Zip Code:		
Telep	phone Numb	er:		Secure Fax Number:				
Send	requested inf	ormation to	THE ATTENTION (OF:				
			IC transmit to us the for rillness/Admission re					_
\square D	ischarge Sun	nmary 🔲	☐ Consult Report by ED Record ☐ Immu	nizations 🔲 (Operative Re		outpatient C	Clinic Note
	nderstand that rsigned with a		ation will be faxed to us.	as at the secure	fax number in	ndicated ab	ove. Please	contact the
Print	ted Name of	Person Com	pleting this Form:					
Signa	ature*:	*: Date:						
			ist be signed by the treati ure and dates.	ng physician or	designated auth	norized repre	esentative. F o	orms will not be
For C	CCHMC HIM cal Record #: _	purposes on	ly: Request Has	Been Fulfilled: [Yes, Initials	Da	nte:	





DTM1024