Akron Children's Hospital

HIPAA AUTHORIZATION to RELEASE MEDICAL RECORDS (FROM Childrens)

MRN

Facility Use Only

Please PRINT and fill out entirely.

Patient Information

Patient Name: _____ ___ ___ _ _____
Last First Middle (any previous name) Date of Birth

_____ _____
Patient Street Address City State Zip Phone

Release To

Release Information TO the following Person(s) or Organizations:

Name/Organization: _____ Attention: _____

_____
Address City State Zip

_____ _____ _____
Phone Fax Email Address

Purpose

Person/Place requesting records (check all that apply):
☐ Patient/Parent/Legal Guardian ☐ Doctor/Hospital ☐Lawyer ☐ Insurance Company ☐ Other _____

Purpose of Release (check all that apply):
☐ Patient Care ☐ Disability ☐ Insurance ☐ School ☐ Legal ☐ Personal Use ☐ Other_____

Method of Release

Format of records to be released:
☐ on paper (will be mailed) ☐ PDF [on CD, Flash Drive, or Email] ☐ Verbal communication only with person or agency listed above
Information May Be Sent Via: ☐ Mail Delivery ☐ Fax ☐ Encrypted Email* ☐ to MyChart* (*electronic records only, size restrictions apply, some records require HIPAA Signed Form)

Information to Release

→ **Dates of Treatment Requested**: _____ (If not specified, the **LAST 6 MONTHS** will be released)

☐ **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 Record, History & Physical, Inpatient Consult Report(s), Operative Report(s), Outpatient Report(s), Radiology, Lab, and other test report(s)

Other Information Requested (choose any to release):
☐ Lab/Pathology Reports ☐ Billing Records
☐ Radiology Reports ☐ Appointment list
☐ Radiology imaging on CD ☐ Demographic page
☐ Vaccination (shot) records
☐ Other imaging (specify): _____

☐ Outpatient/ACHP reports only (specify): _____

☐ **Other** (please list exact documents): _____

Patient/Parent/Legal Guardian

This authorization expires one year from the date of signature, OR on this date / event: _____

I understand that treatment does not depend on me signing this Authorization. I understand that my/my child's/my ward's medical record might have information about sexually transmitted disease (STDs), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It might also have information about mental health problems or services, and/or treatment for alcohol or drug abuse. I understand that if I release records to someone other than a doctor, insurance company, hospital or other health-related organization, these records may no longer be protected by the Federal privacy regulations, and this person or organization might release the records to someone else, except as prohibited by 42 CFR Part 2 or other applicable law. I understand that I can revoke or cancel this Authorization at any time, but this does not apply to records that were already released. If I want to revoke it, I must notify the Privacy Officer, in writing, at Akron Children's Hospital, One Perkins Square, Akron, OH 44308.

By signing below, I affirm that I am the patient and/or the patient's personal representative, and have the authority to authorize who may access or receive the patient's health information.

Mandatory My relationship to the patient is: ☐ Self ☐ Parent ☐ **Legal Guardian-if this box is checked, you must attach Court Order to show your authority to sign***

_____ _____ _ _ _ _
Signature of Patient or Parent/Legal Guardian Printed Name Date

_____ _____ _ _ _ _
Signature of Witness Printed Name Date

Submit

Submit completed form AND a copy of a valid Photo ID (if a current one is not on file with us) to:

Mail form to:	**Fax** form to:	**Email** form to:	**Questions? Call**:
Akron Children's Hospital- Attn: HIM One Perkins Sq., Akron, OH 44308	330-543-5360	records@akronchildrens.org	330-543-8552

PRINT to Sign **SAVE Form**