Akron Children's Hospital

HIPAA AUTHORIZATION to RELEASE MEDICAL RECORDS (TO Children's)

Please PRINT and fill out entirely.

MRN

_____

Facility Use Only

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 Akron Children's Hospital

Choose one: ☐ Akron Campus ☐ Mahoning Valley Campus

Address: One Perkins Square, Akron, OH 44308 — 6505 Market Street, Youngstown, OH 44512

Name/Dept: _____ Attention: _____

(_____) _____ (_____) _____ _____
Phone Fax Email Address

Release FROM

Release FROM the following Person(s) or Organizations:

Name: _____ (_____) _____
Phone

_____ (_____) _____
Street Address City State Zip Fax

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 _____

→ Information to Release

Dates of Treatment Requested: _____

☐ **Medical Record Abstract** – pertinent information generally used for continued care/personal use/disability.
The following items are included in a Medical Record Abstract:
After Visit/Discharge Summary, Emergency Record
History & Physical, Inpatient Consult Report(s)
Operative Report(s), Radiology Reports,
Lab or Other Tests

Other Information Requested (choose any to release):
☐ Vaccination (shot) records
☐ Radiology Reports
☐ Radiology Images on disc
☐ Lab results (blood work)
☐ Pathology Report
☐ Billing Records
☐ Appointment list
☐ Demographics page

☐ **Doctor's Office Reports** (Doctor or Department Name) _____

☐ **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.

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

My relationship to the patient is ☐ Self ☐ Parent ☐ Legal Guardian – Attach Court Order to show your authority to sign

_____ _____ _____/_____/_____
Signature of Witness **Printed Name** **Date**