



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 <u>TO</u> 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)						
	☐ Outpatient/ACHP reports only (specify): _____						
	☐ Other (please list exact documents): _____						
Patient/Parent/Legal Guardian	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): _____						
	This authorization expires <u>one year</u> from the date of signature, <u>OR</u> 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*						
Submit	Signature of Patient or Parent/Legal Guardian _____ Printed Name _____ Date _____						
	Signature of Witness _____ Printed Name _____ Date _____						
	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: Akron Children's Hospital- Attn: HIM One Perkins Sq., Akron, OH 44308		Fax form to: 330-543-5360		Email form to: records@akronchildrens.org		Questions? Call: 330-543-8552	

PRINT to Sign

SAVE Form