Authorization for Use and/or Disclosure of Protected Health Information

Cincinnati Children's Hospital Medical Center

MEDICAL RECORD #: _____

PATIENT INFORMATION (Please Print)

Last Name	First Name	Middle Initial	Maiden Name (if applicable)	Gender
Address	City	State	Zip Code	Phone Number
Date of Birth		Social Security Number (optional)		Email Address (optional)

Please check/specify the information which you want to be used and/or disclosed as a result of this Authorization. *Failure to specify (including dates) will render this Authorization invalid*.

Dates of Treatment/Particular Illness/Admission Requested: _____

☐ **Patient/Physician Abstract – pertinent information generally used for continued care/personal use.**
(See the reverse of this form for information regarding what is included in a Patient/Physician Abstract.)

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Operative Reports
- ☐ Emergency Department Record
- ☐ Consultation Reports
  Specify MD_____
- ☐ Outpatient Clinic Notes
  Specify Clinic _____
- ☐ X-Ray Reports, Labs or Other Tests
- ☐ Registration Sheets
- ☐ Immunizations
- ☐ Other _____
- ☐ Other _____

Purpose For Disclosure
- ☐ Medical Care
- ☐ Attorney/Legal
- ☐ Personal
- ☐ Insurance
- ☐ Disability/SSI
- ☐ Other _____

NOTE: All inpatient and outpatient medical records do not include psychotherapy notes.

Disclose Records To:	
Name	
Organization/Company	
Title	
Street Address	
City, State, Zip	
Telephone Number	

Information May Be: ☐ Mailed ☐ Reviewed Only ☐ Picked Up By whom: _____ ☐ In-Person Meeting

This Authorization will expire 60 days after the date below, or sooner by my choice, in which case, Authorization will expire on _____, or _____ (event) occurs. This Authorization may be revoked at any time to the extent that use and/or disclosure has not already occurred prior to your request for revocation. In order to revoke the Authorization the individual/parent/legal guardian must submit a revocation request in writing to the Health Information Management department, 636 – 8233. Please refer to Cincinnati Children's Hospital Medical Center's (CCHMC) Notice of Privacy Practices.

CCHMC will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization. The information used or disclosed as a result of this Authorization may be subject to redisclosure by the person or entity receiving such information, and thus no longer protected by the federal privacy regulations.

I, the undersigned, hereby authorize Cincinnati Children's Hospital Medical Center to use and/or disclose information from my (or give relationship) _____ medical or financial record as specified above. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above mentioned entity(s).

Information regarding requesting records and fees is provided on the reverse of this form.

Signature: **Date:** ☐ **Patient** ☐ **Parent** ☐ **Legal Guardian***

The above statements must be signed and dated to be valid. If the patient is an emancipated minor or 18 years of age, he/she is required to sign the Authorization. If CCHMC requests this Authorization for its own use or disclosure, a copy of this Authorization must be provided to the individual completing this form.

Documentation regarding guardianship must be provided in order to comply with the above request.

Request Has Been Fulfilled: ☐ **Yes, Initials _____ Date _____**