AUTHORIZATION to RELEASE MEDICAL RECORDS

(TO and/or FROM Children's)

Facility Use Only

MRN _____

PATIENT Name _____ Date of Birth _____
Last First MI

Address _____ Phone _____
Street City State Zip

Release records TO and/or FROM: **AKRON CHILDREN'S HOSPITAL**

Name/Dept: _____ Phone: _____ Fax: _____

☐ ***Release TO*** ☐ ***Receive FROM*** ***the following Person(s) or Organizations:***

Name: _____

Address: _____
Street City State Zip

Phone: _____ ***Fax:*** _____

Person or Place that is requesting records:

☐ Patient/Parent/Guardian ☐ Doctor/Hospital ☐ Lawyer ☐ Insurance Company ☐ Other _____

Reason records are needed:

☐ Patient Care ☐ Disability ☐ Insurance ☐ School ☐ Legal ☐ Other _____

Release the records checked below, ☐ verbally ☐ on paper **or** ☐ electronically (if available) ☐ to MyChart (if available)

☐ Visit/Discharge summary
☐ Chart summary
☐ Emergency room report
☐ Vaccination (shot) records
☐ Pathology report
☐ Lab results
☐ X-ray reports or ☐ Films
☐ Doctor's office reports [Doctor name _____]
☐ Entire chart
☐ Other _____
☐ Surgery report
☐ Billing records

***Treatment dates*:** _____

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.

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.

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

My relationship to the patient is:

☐ Parent ☐ Legal Guardian * ☐ Self ☐ Other _____

***Attach legal papers to show your authority to sign.**

_____ _____ _____
Signature of Witness Printed Name Date