Children's Community Practices

An Affiliate of Nationwide Children's Hospital

MR#_____

AUTHORIZATION TO ACCESS OR DISCLOSE PROTECTED HEALTH INFORMATION

This form allows release of patient information to a 3rd party with patient/parent/guardian permission.

Please note that each section of the form must be completed in its entirety.
Failure to specify (including dates) will delay the process of your request.

Patient Information	Last Name	First Name	Middle
	Date of Birth		Other possible names
	Phone #	Address	
	City	State	Zip Code
Release to	**I hereby authorize Children's Community Practices to use or disclose my protected health information as indicated below to:**		
	□ Mailed □ Reviewed Only □ Pick Up		
	Name		
	Address		
	City	State	Zip Code
	Phone #	Fax	
Information to be disclosed	**Please tell us about the information you need:**		
	From (date)		To (date)

□ Pertinent Package (Most recent H&P, D/S, OP Note, Consult, X-ray report, Test results)
□ Discharge Summary □ Operative Reports
□ Outpatient Clinic Records (please specify clinic/department) _____
□ X-Ray Reports, Labs, or other Tests □ Images on CD □ Photos
□ History and Physical □ Immunizations □ Consultation Reports □ List of Visit Dates
□ Other Information _____
□ Testimony

By checking the box(es) below, I am also requesting access to the following sensitive information.
□ Mental health
□ HIV related information (including AIDS related testing)
□ Alcohol/drug abuse treatment

Please describe the purpose for which the information will be used or disclosed.

_____

_____

_____

Patient: _____ Date of birth: _____

1. If I am receiving treatment related to mental health or substance abuse, I specifically permit Children's Community Practices (CCP) to use my protected health information maintained by the State of Ohio, the Ohio Department of Mental Health, the Ohio Department of Alcohol and Drug Addiction Services, and the Franklin County ADAMH Board to obtain payment for services. Children's Community Practice's may also disclose my protected health information to the above-named entities to obtain payment for services.
2. I understand that this authorization will expire one year from the date of my signature below.
3. I understand that I may shorten, extend, or revoke this authorization at any time by notifying the Children's Community Practice at which I originally delivered this form, in writing. This authorization will be shortened, extended or will cease to be effective on the date the written instructions are received, except to the extent action has already been taken in reliance upon it.
4. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by state or federal privacy regulations. However, other state or federal laws may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
5. I understand that my refusal to sign this Authorization will not jeopardize my right to healthcare and payment for my healthcare, except where disclosure of my protected health information is required for the provision of healthcare or to obtain payment for healthcare.
6. I understand that I can request a copy of this form after I sign it.

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

Signature: _____ Print Name: _____

Relationship to Patient: _____ Date/Time: _____

For Internal Use Only – Verification of Identity Check all means of verification as applicable		
In Person	**In Writing**	**Over Phone**
☐ Driver's License or other government issued picture ID ☐ If no picture ID, 3 forms of identification with name on them ☐ _____ ☐ _____ ☐ _____	☐ Verified Patient/parent information in System ☐ Verified signature against documents already on file	☐ Billing Address ☐ Patient's Date of Birth ☐ Mother's SSN ☐ Child's middle name ☐ Social Security Number ☐ MR# or Account # if known ☐ Insurance ID number ☐ Auditory recognition/voice recognition