Chillicothe Pediatrics

An Affiliate of Nationwide Children's Hospital

MR#_____

MEDICAL RELEASE-AUTHORIZATION TO RECEIVE PROTECTED HEALTH INFORMATION

This form allows the patient or the patient's representative to request individual identifiable health information to be received by the practice.

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

Requested From

I hereby request my protected health information be sent to Chillicothe Pediatrics as indicated:

□ E-mailed □ Mailed □ Faxed □ Patient Pick Up

Name		
Address		
City	State	Zip Code
Phone #	Fax	Email

**if you select the e-mail option, you hereby acknowledge and accept the inherent risk associated with an unsecured e-mail transmission, which can place your information at risk of being read or accessed by someone else, and you agree that CCP will not be responsible for disclosures that might occur in transit.*

Information to be disclosed

Please provide specific information as indicated:

From (date) To (date)

□ X-Ray Reports, Labs, or other Tests
□ History and Physical □ Immunizations □ Consultation Reports □ List of Visit Dates
□ Entire Legal Medical Record (Including, but not limited to: Consent Forms, Insurance ID Cards, Flowsheets, etc.)
□ Other Information _____

This authorization shall remain in effect until _____

I have the right to revoke this authorization, in writing, at any time, by sending such written notification to **Chillicothe Pediatrics at 1264 Hospital Rd. Chillicothe, OH 45601 Fax (740.779.9116)**. However, my revocation will not be effective to the extent that **Chillicothe Pediatrics** has taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. A copy or facsimile transmission of the original of this authorization shall be treated with the same force and effect as the original hereof.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of the information and no longer protected by the HIPAA Privacy Rule.

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 this patient's health information.

_____

Signature of Patient/Parent or Guardian Date

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

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Designation of another Person to Consent for Treatment of Minor Child

In the event I, _____, cannot accompany my child, _____, _____,
(parent/legal guardian) (child's name) (date of birth)
to his/her appointment(s). I give permission to the following person(s) to consent to any necessary examination, medical diagnosis and/or medical care including, but not limited to vaccines listed on the AAP's recommended vaccine schedule, to be rendered to the above named minor child under the general or special supervision and on the advice of any provider of the practice.

1. _____ **2.** _____
(name of designee) (relationship to patient) (name of designee) (relationship to patient)

3. _____ **4.** _____
(name of designee) (relationship to patient) (name of designee) (relationship to patient)

Expiration of Permission (check one):

_____ This form will remain in effect until revoked by written notice.

_____ This form is VALID ONLY during the following time frame:

Effective date: _____/ Expiration date: _____

_____
Parent or legal guardian (Please print name)

_____
Signature of parent or legal guardian Date

_____
Witness (Please print name)-MUST be 18 years or older and not the person receiving consent to treat

_____
Signature of witness Date

Instructions: Please provide your child's health insurance card and copay as applicable at each appointment. It is further agreed that if the parent or legal guardian wishes to discuss the medical care with the physician, a telephone consultation may be scheduled.