

AUTHORIZATION TO ACCESS OR RELEASE PROTECTED HEALTH INFORMATION

Indicate purpose: ___ Review of/access to medical record ___ Request to release copies to third party

I hereby authorize Nationwide Children's Hospital to disclose the following personal health information about me as instructed below.

(Patient Name) (Date of Birth) (Nationwide Children's MR#)

(Address) (City) (State) (Zip) (Phone)

1. Description of Record(s) to be Released/Disclosed:

- Inpatient record(s) including psychiatric, drug, alcohol, and/or HIV/AIDS information.
Specify dates _____
- Discharge Summary(ies) including psychiatric, drug, alcohol, and/or HIV/AIDS information.
Specify dates _____
- Emergency department record(s) including psychiatric, drug, alcohol, and/or HIV/AIDS information.
Specify dates _____
- Clinic records (please specify exact location and dates) including psychiatric, drug, alcohol, and/or HIV/AIDS information. _____
- Other Outpatient record(s) including psychiatric, assessment & counseling, drug & alcohol, and/or HIV/AIDS information. Specify dates _____
- Other information (please be specific) including psychiatric, drug, alcohol, and/or HIV/AIDS information. _____

2. Name(s) of Individuals or Entities to Which the Record(s) Should be Disclosed:

NATIONWIDE CHILDREN'S may release my personal health information, as specified above to the following person(s) or group of persons (provide complete name and address)

(Name) (Phone) (Fax)

(Address) (City) (State) (Zip)

3. The purpose of the authorized use or disclosure of the information described above is as follows:

- Transfer of Records to New Treatment Provider
- Insurance Review or Dispute
- Attorney Review
- School Examination
- Personal Use
- Other (be specific) _____

Other Information:

1. I understand that if the person or entity that receives the above information is a not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
2. As described in the Notice of Privacy Practices of Nationwide Children's, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Nationwide Children's in reliance on this authorization, by sending a written revocation to Nationwide Children's Health Information Management Department, 700 Children's Drive, Columbus, OH 43205.
3. This authorization will expire in one year from the date signed unless specified differently below:
 - End of research study (applicable only if the authorization is for a research study or for creation and maintenance of a research database or research repository)
 - Other (insert applicable date or specific event) _____

4. I understand that I am not required to sign this authorization form and that Nationwide Children's Hospital will not condition the provision of treatment or payment to me on the signing of this authorization except that Nationwide Children's may condition the provision of research-related treatment to me on the signing of this authorization for the use or disclosure of personal health information for such research. Nationwide Children's may also condition the provision of health care to me that is solely for the purpose of creating protected health information for disclosure to a third party on the signing of this authorization.
5. I understand that Nationwide Children's is permitted by law to deny part or all of my request for access for one or more of the following reasons:
 - My access request form is not signed by the me (the patient) or my representative;
 - My access request form is signed by my representative but the representative has not provided information on the source of his/her authority to act on my behalf;
 - Nationwide Children's does not maintain the information I have requested to copy or inspect;
 - The information I have requested is not part of our records;
 - My request is for psychotherapy notes;
 - My request includes information compiled for litigation;
 - My request includes information held by our laboratory that is not accessible by law;
 - My request includes information created or obtained in the course of research still in progress that includes my treatment and I agreed to this denial of access when consenting to participate in the research;
 - A licensed health professional has determined that the requested access is likely to either endanger me or another person's life or safety or cause substantial harm to me or another person;
 - My request is to copy information and I am an inmate in a correctional facility (I retain the right to inspect the information); or
 - My request relates to certain information that was obtained from a confidential source and Nationwide Children's is not required to provide access to it by law.
6. I understand that Nationwide Children's retains the services of a correspondence/copy service, and that I will be required to pay fees in advance for any copies requested (Note: Radiology/x-ray films are processed by the Radiology Department and have separate fee schedules. Contact the Radiology Department directly for more information.). The fee schedule as defined by Ohio law is available upon request.

Name of personal representative, if applicable

Relationship of personal representative to patient or statement of personal authority

Signature of patient (or patient's representative)
(If a verbal authorization, note this above and document who authorized)

Date

Name of Nationwide Children's representative

Date

For Office Use Only

Verification of Identity

Check all means of verification as applicable

In Person	In Writing	Over Phone
<input type="checkbox"/> Driver's License or other government issued picture ID <input type="checkbox"/> If no picture ID, 3 forms of identification with name on them <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> Verified patient/parent information in SMS. <input type="checkbox"/> Verified signature against documents already on file	<input type="checkbox"/> Billing address <input type="checkbox"/> Patient's Date of Birth <input type="checkbox"/> Mother's SSN <input type="checkbox"/> Child's middle name <input type="checkbox"/> Social Security Number <input type="checkbox"/> MR# or Account # if known <input type="checkbox"/> Insurance ID number <input type="checkbox"/> Auditory recognition/voice recognition