

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 protected 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/Accessed:

- 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 Released/Disclosed/Accessed:

NATIONWIDE CHILDREN'S may release my protected 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) _____

