NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.℠

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO NATIONWIDE CHILDREN'S HOSPITAL

I hereby authorize (Indicate name facility/organization/person)_____

at (Address of organization) _____

to release my protected health information as instructed below.

Patient Name: _____Date of Birth:_____

To assist us in easily matching your information to our chart
please verify that the child's name and date of birth are recorded on all documents you send.

Please send the medical records to Nationwide Children's via the following method:

Mail: ATTN: _____ c/o Nationwide Children's, 700 Children's Drive, Columbus, OH 43205
Indicate department/unit/person - Bldg/Room Number or Patient Unit

OR FAX: To the Attention of: _____ Fax number (including area code) _____
Indicate department/unit/person - Bldg/Room Number or Patient Unit

Description of Record(s) to be Released to Nationwide Children's, Columbus, OH
Check all that apply & specify dates:

- ❑ Inpatient record(s) including psychiatric, drug, alcohol, and/or HIV/AIDS information. _____
- ❑ Discharge Summary(ies) including psychiatric, drug, alcohol, and/or HIV/AIDS information. _____
- ❑ Emergency department record(s) including psychiatric, drug, alcohol, and/or HIV/AIDS information. _____
- ❑ 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. _____
- ❑ Other information including psychiatric, drug, alcohol, and/or HIV/AIDS information (**please be specific**)_____

_____

Specify Date(s)_____

_____

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

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

Other Information:

1. 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.

2. I understand that I am not required to sign this authorization form and that Nationwide Children's will not condition the provision of treatment or payment to me on the signing of this form.

3. I understand that if the person or entity that receives the above information is a not a health care provider 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.

4. This authorization will automatically expire in 60 days if no expiration option is checked below:
   * Expire immediately upon receipt of information by Nationwide Children's
   * Other (insert applicable date or specific event) _____

Signature of Parent/Legal Guardian (include relationship to patient)_____ Date/Time _____

Full Address _____

Home Phone Number _____

Name of Nationwide Children's representative (as applicable) _____ Date/Time _____