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

❑ **COMPLETED**
(Clinic/Radiology provided records today)

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

This form allows the patient or the patient's personal representative to request access and/or copies to individual identifiable health information contained in the designated record set. Please note that each section of the form must be completed in its entirety. Failure to specify, including dates, will delay the processing of your request.

PATIENT INFORMATION

Last Name	First Name	Middle
Date of Birth / /	Other possible names (e.g. maiden, preferred, etc.)	
Address		Phone #
City	State	Zip Code

ACCESS METHOD

I hereby request Nationwide Children's to provide access and/or copies of my protected health information as indicated below.

SELECT A FORMAT THEN CIRCLE A DELIVERY METHOD

❑ Access & Review Onsite ❑ Fax # _____

❑ CD – Mail to address below *or* Pick up ❑ Thumb/Flash Drive – Mail to address below *or* Pick up
❑ Paper – Mail to address below *or* Pick up

❑ Electronically – MyChart *or* Email *or* Send to an eligible app (subject to availability)
E-mail _____
App _____

**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 NCH will not be responsible for disclosures that might occur in transit.*

Name		
Address		
City	State	Zip
Phone #	Email	

INFORMATION REQUESTED

From Date: / / **To Date:** / /

❑ Entire Legal Medical Record (including, but not limited to: Consent Forms, Insurance ID Cards, Flowsheets, etc.)

❑ Summarized Inpatient Record (including: History and Physical, Consult Report, Operative Report, Discharge Summary, and Test Results)

❑ Operative Reports ❑ Discharge Summary ❑ Emergency Department Record ❑ Urgent Care Record

❑ X-ray Reports ❑ Lab Results ❑ Other Test Results _____

❑ Images on CD

❑ Outpatient Clinic Records (please specify clinic/department) _____

❑ Well Child or Physical Visit ❑ Immunizations ❑ List of Visit Dates ❑ Summary/Explanation of PHI

❑ Other Information _____

SENSITIVE INFORMATION

By checking the box(es) below, I am requesting access to the following sensitive information. *If Alcohol/Drug Related Treatment records are being requested, please complete the OCC-775, Behavioral Health Authorization to Disclose Information Form.*

❑ Substance Abuse
❑ HIV related information (including AIDS related testing)
❑ Mental Health
❑ Other Information _____

1. I understand that NCH will charge me a flat fee of $6.50 for a copy of these medical records (in all formats), unless extraordinary circumstances apply. *(There is no fee associated with obtaining an immunization record, list of visit dates, or reviewing the requested records onsite.)* Any request for a Summary/Explanation of PHI will be charged separately and the amount of fees imposed for such Summary must be agreed upon by you and NCH in advance.

   Please indicate how you would like to pay for a copy of these records:

   ☐ Debit or Credit Card
   (When your records request has been completed, the Release of Information team will contact you by phone to obtain your payment.)

   ☐ Cashier's Check or Money Order Upon receipt of payment, records will be delivered
   (*Please make payable to: Nationwide Children's Hospital, Attn: HIM Dept.)*

2. Submit the Completed Form/Payment:

   By Mail: Nationwide Children's Hospital
   Attn: HIM Dept.
   700 Children's Drive
   Columbus, Ohio 43205
   By Email: MedicalRecordRequests@nationwidechildrens.org
   By Fax: Health Information Management at 614-355-0797

3. I understand that this request will expire one year from the date of my signature below. During that time, I may request the same information without needing to fill out a new form. I understand that if I need new/additional/different information than what is listed on this form, I will need to complete and submit a new form.

4. I understand that I can request a copy of this form after I sign it. A photocopy of this form will be considered as valid as the original.

5. I understand that depending on the information being requested, there may be a delay in processing this request. Should the completion of this request take longer than 30 days, you will be notified in writing by the Release of Information team. NCH may extend the time to provide access to you by an additional 30 days so long as NCH provides you with a written statement regarding the reason for the delay within 30 days from your request.

6. I understand that NCH may deny this request, in whole or in part, under limited circumstances as provided for under federal and state law if the access requested is reasonably likely to endanger the life or physical safety, or cause substantial harm, to the patient or another person. In the event NCH denies you access, NCH must provide you with a written denial which sets forth the basis of the denial.

Should you have any questions or concerns, please feel free to contact us by phone at 614-355-0777.

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.

_____ _____
Printed Name of Patient (or Personal Representative) Relationship to Patient

_____ _____
Signature of Patient (or Personal Representative) Date/Time

For NCH 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 ❑ Outpatient Care Code