



Request For Access to Protected Health Information

Patient Information	Last Name: _____ First Name: _____ Middle: _____							
	Date of Birth: / / Other Possible Names (e.g., maiden, preferred, etc.): _____							
	Address: _____ Phone #: _____							
	City: _____ State: _____ Zip Code: _____							
Release To	Name: _____							
	Address: _____							
	City: _____ State: _____ Zip Code: _____							
	Email: _____ Phone #: _____							
<i>I hereby request Nationwide Children's to provide access and/or copies of my protected health information as indicated above.</i>								
Access Method	Select a Format: <input type="checkbox"/> Access/Review Onsite <input type="checkbox"/> MyChart <input type="checkbox"/> CD <input type="checkbox"/> Thumb/Flash Drive <input type="checkbox"/> Paper							
	<input type="checkbox"/> Email: _____ <input type="checkbox"/> Fax #: _____							
Select a Delivery Method: <input type="checkbox"/> Mail to address above <input type="checkbox"/> Pick up at - 255 E. Main Street Columbus, Ohio 43215								
<i>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 accessed by someone else, and you agree that NCH will not be responsible for disclosures that might occur in transit.</i>								
Purpose	Purpose of Release (check all that apply):							
	<input type="checkbox"/> Patient Care <input type="checkbox"/> Disability <input type="checkbox"/> Insurance <input type="checkbox"/> School <input type="checkbox"/> Legal <input type="checkbox"/> Personal Use <input type="checkbox"/> Other _____							
Requested Information	Dates of Treatment Requested: From Date: / / To Date: / /							
	<input type="checkbox"/> Summarized Inpatient Record (including History and Physical, Consult Report, Operative Report, Discharge Summary, and Test Results) <input type="checkbox"/> Operative Report <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Emergency Department Record <input type="checkbox"/> Urgent Care Record <input type="checkbox"/> X-Ray Reports <input type="checkbox"/> Lab Results <input type="checkbox"/> Other Test Results _____ <input type="checkbox"/> Images on CD <input type="checkbox"/> Photos <input type="checkbox"/> Outpatient Clinic Records (please specify clinic/department) _____ <input type="checkbox"/> Well Child or Physical Visit <input type="checkbox"/> Immunizations <input type="checkbox"/> List of Visit Dates <input type="checkbox"/> Entire Legal Medical Record <input type="checkbox"/> Other Information _____							
Parent / Patient / Legal Guardian	<p>I understand that NCH may charge me a fee for requested records in accordance with Federal and State law. (Fee schedule available upon request)</p> <p>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. I understand that I can request a copy of this form after I sign it. A photocopy of this form will be considered as the original.</p> <p>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.</p> <p>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 me access, NCH must provide me with a written denial which sets forth the basis of the denial and how the decision can be reviewed and/or appealed.</p> <p>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.</p>							
	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">_____</td> <td style="width: 50%; border: none;">_____</td> </tr> <tr> <td style="border: none;">Printed Name of Patient (or Personal Representative)</td> <td style="border: none;">Relationship to Patient</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">Signature of Patient (or Personal Representative)</td> <td style="border: none;">Date/Time</td> </tr> </table>	_____	_____	Printed Name of Patient (or Personal Representative)	Relationship to Patient	_____	_____	Signature of Patient (or Personal Representative)
_____	_____							
Printed Name of Patient (or Personal Representative)	Relationship to Patient							
_____	_____							
Signature of Patient (or Personal Representative)	Date/Time							
Submit	By Email: MedicalRecordRequests@nationwidechildrens.org							
	By Fax: Health Information Management 614-355-0797							
By Mail: Nationwide Children's Hospital Attn: HIM Dept. 700 Children's Drive Columbus, Ohio 43205								

Tips for Requesting Medical Record Copies

Payment for Medical Records

A cost-based fee will be charged for records provided in all formats (excluding MyChart). Shipping fees will also be charged when applicable. Records provided via MyChart will be **FREE** of charge.

Payment Options:

- **Debit or Credit Card:** The Release of Information team will contact you by phone to process payment once your request is complete.
- **Cashier's Check or Money Order:** Make payable to Nationwide Children's Hospital, Attn: HIM Dept. Records will be delivered upon receipt of payment.

Types of Medical Information You Can Request

Summarized Inpatient Record	Includes History and Physical, Consult Report, Operative Report, Discharge Summary, and Test Results.
Operative Report	Detailed account of surgical procedures performed during an inpatient or outpatient visit.
Discharge Summary	Summary of your hospital stay, including diagnosis, treatment, and follow-up instructions.
Emergency Department Record	Documentation of your visit to the emergency department, including diagnosis and treatment provided.
Urgent Care Record	Records from visits to urgent care, including diagnosis, treatment, and follow-up recommendations.
X-Ray Reports	Written interpretations of X-ray images by a radiologist.
Lab Results	Results of blood tests, urine tests, and other laboratory tests performed.
Images on CD	Digital copies of imaging studies such as X-rays, MRIs, and CT scans.
Photos	Clinical photographs taken for medical documentation and treatment purposes.
Outpatient Clinic Records	Records from visits to outpatient clinics, including consultations, progress notes, and treatment plans.
Well Child or Physical Visit	Documentation of routine check-ups and physical examinations, including growth charts and developmental milestones.
Immunizations	Records of vaccinations received, including dates and types of vaccines administered.
List of Visit Dates	A chronological list of all your medical appointments and visits.
Entire Legal Medical Record	A comprehensive compilation of all medical records maintained for legal purposes, including but not limited to: Consent Forms, Insurance ID Cards, Flowsheets, and other pertinent medical documentation.

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	Records related to the diagnosis and treatment of substance abuse.
HIV Related Information (including AIDS related Testing)	Documentation of HIV status, testing, and related treatments.
Mental Health	Records pertaining to mental health diagnosis, treatment, and therapy sessions.