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

❑ **HIM** to process this request

❑ **Completed - Radiology disk/report provided today**

❑ **Completed - Clinic records provided today**
(Check box if copies already provided)

MR#_____

AUTHORIZATION TO ACCESS OR DISCLOSE PROTECTED HEALTH INFORMATION

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	
Phone #	Address		
City	State	Zip Code	

Release to			
I hereby authorize Nationwide Children's to use or disclose my protected health information as indicated below to:			
Name			
Address	City	State	Zip Code
	Phone#	Fax#	

Information may be: ❑ Mailed ❑ Fax ❑ Reviewed Only ❑ Picked up by:_____

Information to be disclosed

Please tell us about the information you need:

From (date) To (date)

❑ Pertinent Package (Most recent H&P, D/S, OP Note, Consult, X-ray report, Test results)

❑ Inpatient record ❑ Discharge Summary ❑ Emergency Department Record ❑ Operative Reports

❑ Outpatient Clinic Records (please specify clinic location) _____

❑ X-Ray Reports, Labs, or other Tests ❑ History and Physical ❑ Immunizations

❑ Consultation Reports ❑ List of Visit Dates

❑ Other Information_____

Specially Protected Information

I understand that this protected health information may include HIV-related information and/or information relating to diagnosis or treatment of mental illness and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:

❑ Substance Abuse (including alcohol/drug abuse)

❑ Mental Health

❑ HIV related information (including AIDS related testing)

X_____
(Patient Signature required if age 12 or older)

Purpose for the disclosure

Please check purpose of disclosure below:

❑ Changing provider	❑ Second opinion	❑ Continuing care	❑ Legal
❑ Personal use	❑ Insurance	❑ Workers' Compensation	
❑ School	❑ Payment	❑ Other _____	

1. If I am receiving treatment related to mental health or substance abuse, I specifically permit Nationwide Children's to use my protected health information maintained by the State of Ohio, the Ohio Department of Mental Health, the Ohio Department of Alcohol and Drug Addiction Services, and the Franklin County ADAMH Board to obtain payment for services. Nationwide Children's may also disclose my protected health information to the above-named entities to obtain payment for services.
2. I understand that this authorization will expire one year from the date of my signature below.
3. I understand that I may shorten, extend, or revoke this authorization at any time by notifying the Privacy Officer at the address indicated below, in writing. This authorization will be shortened, extended or will cease to be effective on the date the written instructions are received except to the extent action has already been taken in reliance upon it.

   Privacy Officer
   Nationwide Children's Hospital
   700 Children's Drive, Columbus, OH 43205
4. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by state or federal privacy regulations. However, other state or federal laws may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
5. I understand that my refusal to sign this Authorization will not jeopardize my right to healthcare and payment for my healthcare except where disclosure of my protected health information is required for the provision of healthcare or to obtain payment for healthcare.
6. 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.

By signing below, I affirm that I am the patient's representative and have the authority to authorize who may access this patient's health information and to review and/or request changes to this patient's health information.

Signature: _____ Print Name: _____

Relationship to Patient: _____ Date/Time: _____

Mail completed form to: Health Information Management
700 Children's Drive
Columbus, Ohio 43205

or

Fax completed form to : Health Information Management at (614) 355-0797

For Office Use Only

❑ **HIM** to process this request ❑ **COMPLETED** by clinic/unit staff

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