Cincinnati Children's Hospital Medical Center

Authorization for Disclosure of Protected Health Information to

Cincinnati Children's Hospital Medical Center

I, the undersigned, hereby authorize _____ (list entity name, city and state who will disclose records to Cincinnati Children's) to disclose information from my (or give relationship) _____ medical or financial record. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of *AIDS or AIDS*-related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above mentioned entity(s).

PATIENT INFORMATION (Please Print)

Last Name	First Name	Middle Initial	Maiden Name (if applicable)	Gender
Address	City	State	Zip Code	Phone Number
Date of Birth		Social Security Number		Email Address (optional)

Please check/specify the following type of information including dates of treatment, which may be disclosed pursuant to this Authorization:

Dates of Treatment/Particular Illness/Admission Requested: _____

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Operative Reports
- ☐ Emergency Department Record
- ☐ Consultation Reports
  Specify _____
- ☐ Outpatient Clinic Notes
  Specify _____
- ☐ X-Ray Reports, Labs or Other Tests
- ☐ Registration Sheets
- ☐ Immunizations
- ☐ Other _____
- ☐ Other _____
- ☐ ALL INPATIENT MEDICAL RECORDS
- ☐ ALL OUTPATIENT MEDICAL RECORDS

Purpose For Disclosure: ☐ **Medical Care** ☐ **Other** _____

Disclose Records To:	
Name	
Organization/Company	Cincinnati Children's Hospital Medical Center
Title	
Street Address	3333 Burnet Avenue
City, State, Zip	Cincinnati, OH 45229-3039
Telephone Number	(513) 636-

Information may be: ☐ Mailed ☐ Reviewed Only ☐ Picked Up By whom: _____ ☐ In-Person Meeting

This Authorization will expire 60 days after the date below, or sooner by my choice, in which case, Authorization will expire on _____, or _____ (event) occurs.

This Authorization may be revoked at any time to the extent that use and/or disclosure has not already occurred prior to your request for revocation. In order to revoke the authorization the individual/parent/legal guardian must submit a revocation request in writing to the entity disclosing protec ted health information to Cincinnati Children's Hospital Medical Center listed above. Please refer to the above entity's Notice of Privacy Practices.

The entity disclosing protected health information to Cincinnati Children's Hospital Medical Center will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization. The information used or disclosed as a result of this authorization may be subject to redisclosure by the person or entity receiving such information, and thus no longer protected by the federal privacy regulations.

Signature: **Date:** ☐ **Patient** ☐ **Parent** ☐ **Legal Guardian***

The above statements must be signed and dated to be valid. If the patient is an emancipated minor or 18 years of age, he/she is required to sign the Authorization. If CCHMC requests this Authorization for its own use or disclosure, a copy of this Authorization must be provided to the individual completing this form.

****Documentation regarding guardianship must be provided in order to comply with the above request.***