

# Children's Community Practices

An Affiliate of Nationwide Children's Hospital

MR# \_\_\_\_\_

## **MEDICAL RELEASE-AUTHORIZATION TO RECEIVE PROTECTED HEALTH INFORMATION**

*This form allows the patient or the patient's representative to request individual identifiable health information to be received by the practice.*

Please note that each section of the form must be completed in its entirety.  
Failure to specify (including dates) will delay the process of your request.

<b>Patient Information</b>	Last Name	First Name	Middle	
	Date of Birth	Other possible names		
	Phone #	Address		
	City	State	Zip Code	
<b>Requested From</b>	<b>I hereby request my protected health information be sent to <u>Helping Hands Pediatrics</u> as indicated:</b>			
	<input type="checkbox"/> E-mailed <input type="checkbox"/> Mailed <input type="checkbox"/> Faxed <input type="checkbox"/> Patient Pick Up			
	Name			
	Address			
	City	State	Zip Code	
	Phone #	Fax	Email	
<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 read or accessed by someone else, and you agree that CCP will not be responsible for disclosures that might occur in transit.</i>				
<b>Information to be disclosed</b>	<b>Please provide specific information as indicated:</b>			
	From (date)		To (date)	
	<input type="checkbox"/> X-Ray Reports, Labs, or other Tests <input type="checkbox"/> History and Physical <input type="checkbox"/> Immunizations <input type="checkbox"/> Consultation Reports <input type="checkbox"/> List of Visit Dates <input type="checkbox"/> Entire Legal Medical Record (Including, but not limited to: Consent Forms, Insurance ID Cards, Flowsheets, etc.) <input type="checkbox"/> Other Information _____			
	This authorization shall remain in effect until _____			
	I have the right to revoke this authorization, in writing, at any time, by sending such written notification to <b><u>Helping Hands Pediatrics at 5030 N. Walnut St., South Bloomfield, OH 43103.</u></b> However, my revocation will not be effective to the extent that <b><u>Helping Hands Pediatrics</u></b> has taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. A copy or facsimile transmission of the original of this authorization shall be treated with the same force and effect as the original hereof.			
	I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of the information and no longer protected by the HIPAA Privacy Rule.			
	<b>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.</b>			
Signature of Patient/Parent or Guardian			Date	