Children's Community Practices

An Affiliate of Nationwide Children's Hospital

MR#_____

REQUEST FOR RELEASE OF PROTECTED HEALTH INFORMATION

This form allows the patient or the patient's representative to request access and/or copies of 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 process of your request.

Patient Information

Last Name	First Name	Middle
Date of Birth		Other possible names
Phone #	Address	
City	State	Zip Code

Access Method

I hereby request access and/or copies of my protected health information as indicated:

□ Reviewed Only □ Mailed □ Faxed □ Electronically □ Pick Up

□ Paper □ Thumb/Flash Drive □ Patient Portal □ Email □ Eligible App (subject to availability)

Name		
Address		
City	State	Zip Code
Phone #	Fax	Email

**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.*

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)
□ Discharge Summary □ Operative Reports □ Summary/Explanation of PHI
□ Outpatient Clinic Records (please specify clinic/department) _____
□ X-Ray Reports, Labs, or other Tests □ Images on CD □ Photos
□ History and Physical □ Immunizations □ Consultation Reports □ List of Visit Dates
□ Entire Legal Medical Record (Including, but not limited to: Consent Forms, Insurance ID Cards, Flowsheets, etc.)

By checking the box(es) below, I am also requesting access to the following sensitive information.
□ Mental health
□ HIV related information (including AIDS related testing)
□ Alcohol/drug abuse treatment

□ Other Information _____

Patient Name: _____ Date of birth: _____

1. I understand that CCP 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 CCP in advance.

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

☐ Debit or Credit Card ☐ Cashier's Check or Money Order

2. Return the completed form to your local CCP practice.

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. CCP may extend the time to provide access to you by an additional 30 days so long as CCP provides you with a written statement regarding the reason for the delay within 30 days from your request.

6. I understand that CCP 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 CCP denies you access, CCP must provide you with a written explanation which sets forth the basis of the denial.

Should you have any questions or concerns, please feel free to contact your local CCP practice.
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