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.

Patient Information

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

Requested From

I hereby request my protected health information be sent to Hand In Hand Pediatrics as indicated:

□ E-mailed □ Mailed □ Faxed □ Patient Pick Up

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 provide specific information as indicated:

From (date) To (date)

□ X-Ray Reports, Labs, or other Tests
□ 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.)
□ 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 **Hand In Hand Pediatrics at 6051 Memorial Drive, Dublin OH 43017.** However, my revocation will not be effective to the extent that **Hand In Hand Pediatrics** 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.

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.

_____

Signature of Patient/Parent or Guardian Date