



AUTHORIZATION to RELEASE MEDICAL RECORDS

PLEASE PRINT CLEARLY

Facility Use Only

MRN _____

Requestor # _____

I authorize the release of the following patient's medical records by: Akron Children's Hospital

PATIENT Name _____
Last First MI Date of Birth _____

Address _____
Street City State Zip Phone _____

Release records to:

Name _____ Phone/Fax _____

Address _____
Street City State Zip

Person or Place that is requesting records:

Patient/Parent/Guardian Doctor/Hospital Lawyer Insurance Company Other _____

Reason records are needed:

Patient Care Disability Insurance School Legal Other _____

Release the records checked below, on paper or electronically (if available):

Visit/Discharge summary Lab results Surgery report
Chart summary X-ray reports or Films Billing records
Emergency room report Doctor's office reports [Doctor name _____]
Vaccination (shot) records Entire chart
Pathology report Other _____

Treatment dates: _____

This authorization expires one year from the date of signature, OR on this date / event: _____

I understand that treatment does not depend on me signing this Authorization.

I understand that my/my child's/my ward's medical record might have information about sexually transmitted disease (STDs), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It might also have information about mental health problems or services, and/or treatment for alcohol or drug abuse.

I understand that if I release records to someone other than a doctor, insurance company, hospital or other health-related organization, these records may no longer be protected by the Federal privacy regulations, and this person or organization might release the records to someone else.

I understand that I can revoke or cancel this Authorization at any time, but this does not apply to records that were already released. If I want to revoke it, I must notify the Privacy Officer, in writing, at Akron Children's Hospital, One Perkins Square, Akron, OH 44308.

Signature of Patient or Parent/Legal Guardian _____ Date _____

My relationship to the patient is:

Parent Legal Guardian* Self Other _____

***Attach legal papers to show your authority to sign.**

Signature of Witness _____ Date _____