# Authorization for Use and/or Disclosure Of Protected Health Information

**MEDICAL RECORD #:__N/A_______**

**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 that you want to be disclosed pursuant to this authorization. Failure to specify will render this authorization invalid.**

**Dates of LEND Family Mentoring Experience: ________October 2005 – June 2006_______________**

-  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: Information shared with trainee
-  Other ____________________
-  ALL INPATIENT MEDICAL RECORDS (See Note)
-  ALL OUTPATIENT MEDICAL

**Purpose for Disclosure**

-  Medical Care
-  Attorney/Legal
-  Individual Use
-  Insurance
-  Disability/SSI
-  Other: CCDDBP LEND Family Mentoring Experience

*NOTE: All inpatient and outpatient medical records do not include psychotherapy notes.*
** Routinely copied for continuing medical care*

| Disclose Records To: | |
|---|---|
| Name | LEND Program faculty, staff and trainees |
| Organization/Company | CCHMC Division of Developmental and Behavioral Pediatrics – Training Dept. |
| Title | Trainee |
| Street Address | 3333 Burnet Ave. |
| City, State, Zip | Cincinnati, Ohio 45229 |
| Telephone Number | 513-636-4619 |

Records may be:  Mailed  Reviewed by LEND Program faculty, staff, and trainees  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 _June 2005_____. 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 Health Information Management department, 636-8233. Please refer to Cincinnati Children's Hospital Medical Center's (CCHMC) Notice of Privacy Practices.

CCHMC 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. I understand that a standardized fee has been established for copies of medical records. Please inquire regarding these fees prior to requesting copies.

I, the undersigned, hereby authorize Cincinnati Children's Hospital Medical Center to use and/or disclose information regarding my (give relationship)__________________________ as specified above. 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).

**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.

**Request Has Been Fulfilled:  Yes, Initials ________ Date ____________**