CONFIRMATION OF TREATMENT RELATIONSHIP AND REQUEST FOR PROTECTED HEALTH INFORMATION

This document confirms that the following Cincinnati Children's Hospital Medical Center patient, ________________________________ [full name of patient], with a birth date of ______________, is a patient of the physician/physician practice identified below. Our practice information is as follows:

This patient has an appointment date of: _______________________________ Time: ______________

Practice/Physician Name:

Practice Street Address:

City: **State:** **Zip Code:**

Telephone Number: **Secure Fax Number:**

Send requested information **to THE ATTENTION OF**:

We hereby request that CCHMC transmit to us the following patient information for our use in treating the patient:______

Dates of treatment/Particular illness/Admission requested: ____

____

Information to be released: ☐ **Consult Report by Dr.** ____

☐ **Discharge Summary** ☐ **ED Record** ☐ **Immunizations** ☐ **Operative Report** ☐ **Outpatient Clinic Note**

☐ **Other:** ____

We understand that the information will be faxed to us at the secure fax number indicated above. Please contact the undersigned with any questions.

Printed Name of Person Completing this Form:

Signature*: **Date:**

***NOTE:** The completed form **must** be signed by the treating physician or designated authorized representative. **Forms will not be considered valid without signature and dates**.

For CCHMC HIM purposes only:
Medical Record #: _____________________ Request Has Been Fulfilled: ☐ Yes, Initials _______ Date: _________________________

M1024
HIC 02/12

DTM1024