Pediatrics of Lima, Inc.

830 W. HIGH ST., SUITE 102●LIMA, OHIO 45801●PH (419) 222-4045●FAX (419) 228-5665

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

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

PATIENT INFORMATION

Patient Name:	DOB:
Address:	
City/State/ZIP:	
Telephone #:	

AGENCY OR PERSON RECEIVING INFORMATION ******ALL FIELDS REQUIRED******

From:		**To:**	
Person/Institution:		Person/Institution:	
Address:		Address:	
City:		City:	
State/ZIP:		State/ZIP:	
Telephone #:	FAX #:	Telephone #:	FAX #:

ACCESS METHOD

□ USPS **(CHARGES APPLY)**	□ Email Address (**Vaccines and Growth Records Only)***_____
□ Pick Up **(CHARGES APPY)**	□ FAX # _____

No charge if faxed directly to the provider, fax number must be provided as recipient above

**If you select the e-mail option, you herby 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 Pediatrics of Lima, Inc. will not be responsible for disclosures that might occur in transit.*

INFORMATION REQUESTED

From Date:	**To Date:**

□ Summarize Inpatient Record (including: History and Physical, Consult Report, Operative Report, Discharge Summary, Test Results)

□ Emergency Department Record □ Urgent Care Record

□ X-ray Reports □ Lab Results □ Other Test Results

□ Well Child or Physical Visits □ Immunizations □ List of Visits Dates □ School Forms

□ Entire Legal Medical Record (including, but not limited to: Consent Forms, Insurance ID Cards, Flowsheets, etc.)

□ Other Information _____

□ All Records

PATIENT 12 OR OVER MUST AUTHORIZE THIS RELEASE BY CHECKING THE BOX BELOW AND SIGNING:

□ HIV/AIDS related health information and/or records
□ Substance Abuse
□ Behavioral or Mental Health information/and or records *(Release must be witnessed, Patient 12 or over must authorize)*
□ Other Information _____

This authorization will expire in 365 days UNLESS:

Other date is specified here: _____

1. I understand that if paper copies of records are requested there will be a charge. *These fees are based on Ohio Revised Code 3701.742 and adjusted by ODH per ORC 3701.742 according to the annual consumer price index for all urban areas for the preceding year as published by the U.S. Department of Labor.*

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

   □ Debit or Credit Card
   (When your records request has been completed, our Medical Records Specialist will contact you by phone to obtain your payment.)
   □ Check or Cash
   (Please make payable to: Pediatrics of Lima, Inc., Attn. Medical Records)

2. Submit the Completed Form/Payment:
   By Mail/In Person: Pediatrics of Lima, Inc.
   Attn. Medical Records
   830 W. High St., Suite 102
   Lima, Ohio 45801
   By Fax: (419) 228-5665

3. I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and submit it to my healthcare provider. I understand that if I withdraw authorization, no new health information may be shared and the health information already submitted may not be used unless it has already been used in reliance on my previous authorization.

4. 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 that what is listed on this form, I will need to complete and submit a new form.

5. 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.

6. 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 by our Medical Records Specialist. Pediatrics of Lima, Inc., may extend the time to provide access to you by an additional 30 days so long as Pediatrics of Lima, Inc. provides you with a written statement regarding the reason for the delay within 30 days from your request.

7. I understand that Pediatrics of Lima, Inc. 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 reasonable likely to endanger the life or physical safety, or cause substantial harm, to the patient or another person. In the event Pediatrics of Lima, Inc. denies you access, Pediatrics of Lima, Inc. must provide you with a written denial with sets forth the basis of the denial.

Should you have any questions or concerns, please feel free to contact us by phone at (419) 222-4045.

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/Time**

*(For information regarding Behavioral or Mental Health, HIV/AIDS and Sexually Transmitted Diseases, **the patient 12 or over must sign** to release these records.)*

For Mental Health Releases Only:

_____ _____

Signature of Patient 12 or over **Date/Time**

_____ _____

Witness *(Mental Health releases must be witnessed)* **Date/Time**

For Pediatrics of Lima Use Only Verification Identity

Check all means of verification as applicable

In Person	In Writing	Over Phone

□ Driver's License or other government issued picture ID □ If no picture ID, 3 forms of identification with name on them □ _____ □ _____ □ _____	□ Verified patient/parent information in System. □ Verified signature against documents already on file.	□ Billing address □ Patient's Date of Birth □ Account # if known □ Insurance ID number □ Driver's License # □ Child's middle name