NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.℠

Authorization for Routine Disclosure/Exchange of Patient Information

I authorize the following Nationwide Children's Hospital clinic(s)/center(s) to communicate as instructed below, medical, behavioral, and/or school information regarding my child.
(If a complete copy of medical records is needed, please fill out the MR-9 form.)

Patient Name: _____

Date of Birth: _____ MR# _____

Parent/Legal Guardian: _____

I understand that completion of this form will help streamline communications by providing Nationwide Children's permission, in advance, to talk, or send, information to the individuals I designate; such as: to myself via personal email, school nurses, school staff, psychologists, supporting agencies, or extended family members. I understand that this authorization is only binding in the clinics I specify below. Should I select more than one clinic, I will be responsible for the distribution of this form to the other locations. I also understand that Nationwide Children's staff can only honor this authorization when it is made available to them.

Email Acknowledgement:
You have the option below to select email as a routine method of communication for yourself or a designated agency or entity.

***NCH traditionally uses a secure email portal. You have the option of choosing to receive unsecure email communication. However, if you select to not have email sent through NCH's secure portal, you hereby acknowledge and accept the inherent risk associated with an unsecured email transmission, which can place your information at risk of being read or accessed by an unauthorized individual, and you agree that NCH will not be responsible for disclosures that might occur in transit.**

***PLEASE BE SURE TO INDICATE WHICH NCH CLINIC/DEPARTMENT IS DISCLOSING THE INFORMATION.**

RECIPIENT OF INFORMATION:

Name of Agency/Entity Person: **The Ohio Department of Health - Help Me Grow Home Visiting Program**
*NCH Clinic/Department Disclosing Information: **Maternal / Infant Home Visitation - The Center for Family Safety and Healing**
Type of Information to be shared/disclosed: ☒ Medical ☒ Behavioral ☒ School
Delivery Method: ☒ Verbal ☐ Fax ☐ Written ☒ Phone/Leave Voicemail - Yes/No (*If a complete copy of medical records is needed, please fill out the MR-9 form.*) ☐ *Email - Secure: _____ ☐ *Email - Usecure*: _____

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RECIPIENT OF INFORMATION:

Name of Agency/Entity Person: **Nurse-Family Partnership - National Service Office**
*NCH Clinic/Department Disclosing Information: **Maternal / Infant Home Visitation - The Center for Family Safety and Healing**
Type of Information to be shared/disclosed: ☒ Medical ☒ Behavioral ☒ School
Delivery Method: ☒ Verbal ☐ Fax ☐ Written ☒ Phone/Leave Voicemail Yes/No (*If a complete copy of medical records is needed, please fill out the MR-9 form.)* ☐ *Email - Secure: _____ ☐ *Email - Unsecure:_____

RECIPIENT OF INFORMATION:

Name of Agency/Entity Person:
*NCH Clinic/Department Disclosing Information:
Type of Information to be shared/disclosed: ☐ Medical ☐ Behavioral ☐ School
Delivery Method: ☐ Verbal ☐ Fax ☐ Written ☐ Phone/Leave Voicemail- Yes/No (*If a complete copy of medical records is needed, please fill out the MR-9 form.)* ☐ *Email - Secure: _____ ☐ *Email - Unsecure:_____

Notice of Right to Revoke: I understand that this document will remain in force until I revoke it in writing, except to the extent that action has been taken by Nationwide Children's in reliance on this authorization and that treatment will not be conditioned upon signing or revoking this request. I also understand that any information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient.

Expiration Date: ☐ **No Expiration Date** ☐ **One year** ☒ **Other** Until Program Exit
Failure to check one of the expiration boxes permits Nationwide Children's Hospital to assume that there is no expiration date.

_____ _____
Signature of Patient/Legal Guardian Date/Time

_____ _____
Witness Date/Time

For Staff Use Only- Copy provided to family ☐Yes ☐ No- Family did not want copy of form