Cincinnati Children's™
changing the outcome together

HIM Radiology Location: **(513) 636-4217 option 5** Fax Number: **(513) 636-4586**

HIM RADIOLOGY LOCATION
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 information **to THE ATTENTION OF:** **E-Mail Address:**

Information May Be Sent Via: ☐ Fax (Secure Fax Number Listed above) ☐ E-mail (address above) ☐ US Mail (Address above)

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

Dates of Radiology testing (if date(s) unspecified, the most recent **Radiology Testing will be provided):** _____

Information to be released:

Radiology **Report(s):** ☐ X-ray ☐ CT ☐ MRI ☐ Ultrasound ☐ All Reports
☐ Other Radiology Reports *(please specify):* _____
Radiology **Image(s):** ☐ X-ray ☐ CT ☐ MRI ☐ Ultrasound ☐ All Images
☐ Other Radiology Imaging *(please specify)*: _____

We understand that information will be e-mailed, faxed or mailed via US mail as specified 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**

Fax To: (513) 636-4586

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

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