Children's Hospital of Philadelphia

Requesting Medical Records

If you would like to request medical records from CHOP, please complete and fax this authorization to: 215-590-4193, E-mail: HIMROI@chop.edu or mail to:

Health Information Management Department
Children's Hospital of Philadelphia
100 Penn Square East
Suite 800
Philadelphia, PA 19107

***Please note:** CHOP's Health Information Management (HIM) department is not the custodian of all records of CHOP's facilities. We will forward your request to the proper outpatient department at CHOP, but for a faster turnaround you can send directly to a CHOP outpatient site. A full listing of the outpatient records HIM releases can be found at: http://www.chop.edu/patients-and-visitors/obtaining-medical-records

An authorization form should be signed by the patient's parent, legal guardian, or the patient if the patient is 18 years of age or older. An authorization form signed by someone other than the patient (if over 18 years of age), or the patient's parent, must be accompanied by legal guardianship documentation

If you are requesting medical records of a deceased patient, executor or administrator of the estate documentation is needed in addition to your signed request. There are circumstances where a family can request records of a deceased patient without an executor of the estate documentation. Exceptions may apply to previous caretakers or to the guarantor if the request is relevant to payment for care.

If you are requesting records for continuing care, for a school/employer, for patient/family use or for disability purposes, the receiving entity will receive an abstract of the record unless otherwise specified. A medical record abstract contains the following documentation: emergency record, discharge summary, operative/procedure report(s), consultation report(s), history and physical, outpatient office notes, and other diagnostic tests or labs.

By default, an abstract of the chart will be released. If the entire record is to be released, then payment will be applied. The "Entire Record," includes for example, progress notes, flowsheets, orders etc. Please see the CHOP medical records website for applicable state fees.

The information you are requesting may be available already, free of charge, through CHOP's patient portal, MyCHOP. With a MyCHOP account you can view: test results, immunizations, visit and admission summaries, appointment information, medications, as well as a patient's medical history. You can sign up for a MyCHOP account through this link: https://mychop.chop.edu/mychart/. Please note: The portal only provides access to portions of the electronic medical record, it is not an all-inclusive medical record. To obtain your medical records through MyCHOP, please see below.

You can now receive the following medical records through MyCHOP: inpatient, emergency room, same day surgery visits, urgent care records and select outpatient office records. All you have to do is fill out the authorization form and send it to our Health Information Management department via Fax: 215-590-4193 or mail to the address mentioned above.

- ☐ Please note: Only those records documented in the electronic format can be sent through MyCHOP.
- ☐ There is a file size restriction when sending records through MyCHOP. If the file size is too large, the Health Information Management department will contact you to determine the best way for you to receive records.
- ☐ You must use a computer to view the medical records, the records cannot be viewed on a phone or tablet

Children's Hospital of Philadelphia℠

MR-109
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LAST NAME _____ FIRST NAME _____

MR# _____ DOB _____

PLACE PATIENT LABEL HERE *OR* COMPLETE ABOVE

DO NOT HANDWRITE PATIENT INFORMATION HERE

AUTHORIZATION TO RELEASE/OBTAIN PATIENT INFORMATION

This authorizes Children's Hospital of Philadelphia and its affiliates to release/obtain information as described below. For a listing of related entities and medical practices, see Children's Hospital of Philadelphia *Notice of Privacy Practices*.

1. **Patient Name (First, Middle, Last):** _____
   Address of Patient: _____
   City, State, Zip: _____
   Telephone Number: _____ **Date of Birth:** _____

2. **What is the name of the person or facility that will be releasing your information?** Check the appropriate box below and provide the name, address and telephone number of the person/facility releasing the information.
   ☐ **Children's Hospital of Philadelphia** or ☐ **Other**
   Name of Person / Facility: _____
   Address: _____
   City, State, Zip: _____
   Telephone Number: _____ Fax Number: _____

3. **What information will be released?** Date of appointment or hospital stay beginning _____ through to _____
   ☐ **Emergency Department** ☐ **Home Care** ☐ **Outpatient** _____
   ☐ **Inpatient** ☐ **Immunization** *(please specify name of department/office)*
   ☐ **Other Information** *(please specify)* _____
   If there is any part of the record you do not wish released, please indicate here: _____
   If your records contain any information about substance (drug or alcohol) abuse, HIV, or mental health, may this information be released? If yes, please initial next to each type of information to be released:
   Drug and/or alcohol treatment or testing _____ **HIV** _____ **Mental Health** _____

4. **Medical Record delivery format:** If no selection is made, default will be Paper.
   ☐ **Paper** ☐ **CD** ☐ **MyCHOP** *(active account needed)* ☐ **Fax** ☐ **Other** _____

5. **What is the name of the person or facility who is to receive your information?** Check the appropriate box below and provide the name, address and telephone number of the person/facility releasing the information.
   ☐ **Children's Hospital of Philadelphia** or ☐ **Other**
   Name of Person / Facility: _____
   Address: _____
   City, State, Zip: _____
   Telephone Number: _____ Fax Number: _____

6. **Please explain why the person or facility above needs this information:**
   _____

7. **Expiration.** Your permission will expire 90 days after you sign this form unless you indicate otherwise. If you would like to extend your permission for longer than 90 days, please tell us when your permission expires. The date cannot be more than a year from now: _____.

8. **Understanding this Authorization**
   - This allows the release or obtaining of information that exists in the patient's medical record when the form is signed, as well as information created after the form is signed until it expires.
   - I may withdraw my permission at any time by providing written notice to the above-named provider releasing the information. For information being released by Children's Hospital of Philadelphia, see its *Notice of Privacy Practices* for instructions on how to withdraw (revoke) an authorization. If I withdraw my permission, any information that was already released cannot be retrieved.
   - Information released by Children's Hospital of Philadelphia may be released again by the person or organization that receives it and is no longer protected under federal privacy laws. Children's Hospital of Philadelphia will protect information it obtains as required by federal privacy laws.
   - I understand my permission is voluntary and I/my child will receive treatment whether or not I sign this form.

9. **Signature.** By signing, I understand that I am authorizing Children's Hospital of Philadelphia to release/obtain information as described above.

_____ Signature _____ Printed Name _____ / _____ Date Time

Relationship to patient: ☐ Patient ☐ Parent ☐ Legal Guardian ☐ Other: _____

Information Released by: _____ Date: _____

WHITE – MEDICAL RECORDS **YELLOW – PATIENT/PARENT/LEGAL GUARDIAN**