

Dr. Rubin has my permission to send reports to robert.michaels@akronchildrens.com
Please send all reports shared!
parents request



Akron Children's Hospital

AUTHORIZATION for RELEASE of MEDICAL INFORMATION for RESEARCH

Protocol Title/Number

A Patient Name Evans David Michael
(Please Print) Last First Middle
Date of Birth June 26, 1997 Phone _____ MR# 2239287
Address 627 Heritage Trail Apt B Mansfield OH 44905
Street City State Zip

B The undersigned authorizes the use or disclosure of the above named individual's health information by Akron Children's Hospital or its subsidiaries (Children's) as described below:

C 1 Use/Disclose information to the Person(s) and/or Organization(s) listed below and on the attached Information Sheet:
Name Dr. Michael Rubin Phone/Fax 330.843.3279/3760
Address One Perkins Square Akron OH 44308
Street City State Zip
*See attached Information Sheet for a complete listing of the entities with whom information will be shared.

D 2 Purpose of Use of Disclosure:
 At request of patient Research Database or Repository Billing/Payment Other
3. Treatment during clinical trial is CONDITIONED UPON THE SIGNING OF THIS AUTHORIZATION:: Check One: Yes No

E 4. Type of information to be used or disclosed:
 Complete Medical Record Consultation Reports Pathology Reports
 History & Physical Diagnostic Imaging Reports Photographs/videotapes
 Progress Notes Lab Reports Diagnosis & Treatment Codes
 Discharge Summary Radiology Reports/Films Other

5. Treatment date(s) Not applicable

Unless revoked, this authorization will expire at the end of the research study or on the following date or event: no expiration date

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that if the person(s) or class(es) of persons in Sections B 1 are not health care providers, health plans or health care clearing houses covered by the Federal privacy regulations, the protected health information they receive may be further used or disclosed by them and may not be protected any longer by the Federal privacy regulations.

I understand that this Authorization may be revoked at any time, except to the extent that Children's has taken action in reliance on this Authorization. Notify in writing, the Privacy Officer, Akron Children's Hospital, One Perkins Square, Akron, OH 44308. I understand that Children's can use and disclose health information obtained prior to the effective date of such revocation to maintain the integrity of the research data.

I understand that access to my health information may be restricted for the duration of the research study. However, once the study has concluded at all sites, I can inspect and obtain a copy of this information.

Carolina Evans 2/22/2014
Signature of Patient or Parent/Legal Guardian Date

If this Authorization is signed by the Parent/Legal Guardian, please specify the relationship to the patient/authority to sign on behalf of the individual

Signature of Witness Date