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
Buerger Center
Suite P1180
Philadelphia, PA 19104

***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, notes 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.

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Children's Hospital of Philadelphia℠

MR-109
Rev. 5/25

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) use disorder, HIV, or mental health, please initial next to each type of information to be released:
   Substance Use Disorder Treatment/Program Record _____ **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 1 year after you sign this form unless you indicate otherwise. If you would like your permission to expire in less than 1 year, 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 change my mind at any time and take back (revoke) my permission in this form by providing written notice to the above-named provider releasing the information. For information being released by CHOP, see CHOP's *Notice of Privacy Practices* for instructions on how to revoke an authorization. If I revoke this permission, I understand that the revocation will only apply to future releases of my information and that any information that was already released or obtained cannot be retrieved or removed.
   - If this authorization allows the release of Substance Use Disorder Program Records, I understand that information released by CHOP to my other treating providers, my health plans, or CHOP contractors for purposes of treatment, payment and healthcare operations may generally be released again by the recipient in accordance with the Health Insurance Portability and Accountability Act (HIPAA) unless other laws further limit the use and disclosure by the recipient. For example, the recipient's authority to use or release the information in civil, criminal, administrative or legislative proceedings will remain limited.
   - Information released by CHOP to recipients that are not covered by HIPAA may be released again by the recipient and may no longer be protected under federal privacy laws. Children's Hospital of Philadelphia will protect information it obtains as required by federal privacy laws.
   - 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: _____

OUR COMMITMENT TO DIVERSE POPULATIONS

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Children's Hospital of Philadelphia complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Children's Hospital of Philadelphia does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

CHILDREN'S HOSPITAL OF PHILADELPHIA:

- Provides reasonable modifications and free aids and services to help people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call 800-879-2467.

If you believe that Children's Hospital of Philadelphia has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, or any other protected classification, you can contact the Section 1557 Coordinator (1557coordinator@chop.edu) or file a grievance with:

The Family Relations Office
3401 Civic Center Blvd., Philadelphia, PA 19104
Phone: 267-426-6983

• email: familyrelations@chop.edu.

You can file a grievance in person or by mail, or email.

If you need help filing a grievance, Family Relations is available to help you.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Ave. • SW Room 509F, HHH Building • Washington, DC 20201
Phone: 800-368-1019; 800-537-7697 (TDD)

Complaint forms are available at hhs.gov/ocr/office/file/index.html.

This notice is available at https://www.chop.edu/nondiscrimination-statement

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services (§ 92.11)

English
ATTENTION: If you speak, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-879-2467, then press 1 or speak to your provider.

Español - Spanish
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-879-2467, luego presione 1 o hable con su proveedor.

中文- Chinese
注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-879-2467 然后按 1 或咨询您的服务提供商。

Arabic
العربية
تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 18008792467، ثم اضغط على الرقم ١.

РУССКИЙ - Russian
ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-879-2467 затем нажмите 1 или обратитесь к своему поставщику услуг.

Português - Portuguese
ATENÇÃO: Se você fala Português, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-879-2467 em seguida, pressione 1 ou fale com seu provedor.

Việt - Vietnamese
LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-879-2467 sau đó nhấn 1 hoặc trao đổi với người cung cấp dịch vụ của bạn.

Français - French
ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-879-2467 puis appuyez sur 1 ou parlez à votre fournisseur.

Kreyòl Ayisyen - Haitian-Creole
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan 1-800-879-2467 apre sa peze 1 oswa pale avèk founisè w la.

Italiano - Italian
ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1-800-879-2467 poi premi 1 o parla con il tuo fornitore.

한국어 - Korean
주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-879-2467 그런 다음 1 을 누르세요 번으로 전화하거나 서비스 제공업체에 문의하십시오.

नेपाली - Nepali
नोट: यदि तपाईं नेपाली बोल्नुहुन्छ भने तपाईंलाई निःशुल्क भाषा समर्थन सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त समर्थन र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-800-879-2467 मा कल गर्नुहोस् र त्यसपछि 1 थिच्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

हिंदी - Hindi
ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-879-2467 फिर 1 दबाएँ। पर कॉल करें या अपने प्रदाता से बात करें।

Deutsch - German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-879-2467 an, dann drücken Sie die 1 oder sprechen Sie mit Ihrem Gesundheitsdienstleiter.

ગુજરાતી - Gujarati
ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑકિઝલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-800-879-2467 પછી 1 દબાવો પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

Polski - Polish
UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-879-2467 następnie naciśnij 1 lub porozmawiaj ze swoim dostawcą.

українська мова - Ukrainian
УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-800-879-2467 потім натисніть 1 або зверніться до свого постачальника.

Tagalog – Tagalog
PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-879-2467 pagkatapos ay pindutin ang 1 o makipag-usap sa iyong provider.

తెలుగు - Telugu
సావధానం: మీరు తెలుగు మాట్లాడితే, మీకు ఉచిత భాషా సహాయ సేవలు అందుబాటులో ఉంటాయి. యాక్సెస్ చేయగల ఫార్మాట్‌లలో సమాచారాన్ని అందించడానికి తగిన సహాయక సహాయాలు మరియు సేవలు కూడా ఉచితంగా అందుబాటులో ఉంటాయి. 1-800-879-2467 తర్వాత 1 నొక్కండి కి కాల్ చేయండి లేదా మీ ప్రొవైడర్‌తో మాట్లాడండి.

Deitsch - Pennsylvania Dutch
Wann du Deitsch (Pennsylvania German/Dutch) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. G'geignete Hilfsmiddel un Dienscht fer Information in zugängliche Formate sin aa fer nix do. Ruf 1-800-879-2467 aa, dann drick 1 odder schwetz mit dei Dienschtleistender.