NATIONWIDE CHILDREN'S

When your child needs a hospital, everything matters.℠

ACCOUNTING REQUEST FORM

You have the right to receive an accounting of certain disclosures made by Nationwide Children's Hospital of your child's health and medical information. The following information is required in order for us to process your request.

Patient Name____ Date of Birth ________________

Name & address accounting to be mailed to: ____

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Home telephone number ____________________________

Entities from which you wish to receive accounting (each entity billed separately):

- ❑ Nationwide Children's Hospital
- ❑ Nationwide Children's Hospital Behavioral Health
- ❑ The Research Institute at Nationwide Children's Hospital
- ❑ Nationwide Children's Hospital Foundation
- ❑ Children's Surgical Associates Corporation
- ❑ Children's Radiological Institute
- ❑ Pediatric Pathology Associates of Columbus
- ❑ The Child and Family Advocacy Center at Nationwide Children's Hospital
- ❑ Nationwide Children's Hospital Homecare Services
- ❑ Pediatric Academic Association
- ❑ Patient Accounts (copies of your bill)
- ❑ Other (please specify)

Period of time for which you wish to see the disclosures made. Note that you can request a list of disclosures for any time period after April 14, 2003. ___________________________________

We are not required by law to include any of the following disclosures of your health information in an accounting to you:

- Disclosures made pursuant to an authorization signed by you or your representative;
- Disclosures to carry out our own or other providers' treatment, payment and health care operations;
- Disclosures made to you or your personal representative;
- Disclosures to our facility directory;
- Disclosures made to persons involved in your care or notification of next-of-kin or family members;
- Disclosures for national security or intelligence purposes;
- Disclosures to correctional institutions or law enforcement officials about inmates or others in custody; or
- Disclosures that occurred prior to April 14, 2003.

If you request more than one accounting in any 12-month period, we will charge you $25 for each subsequent accounting requested.

Patient Printed Name ____________________________

Patient/Legal Guardian ____________________________ Date ______________________

Note that no accounting request will be processed unless you, the legal guardian have signed this form.