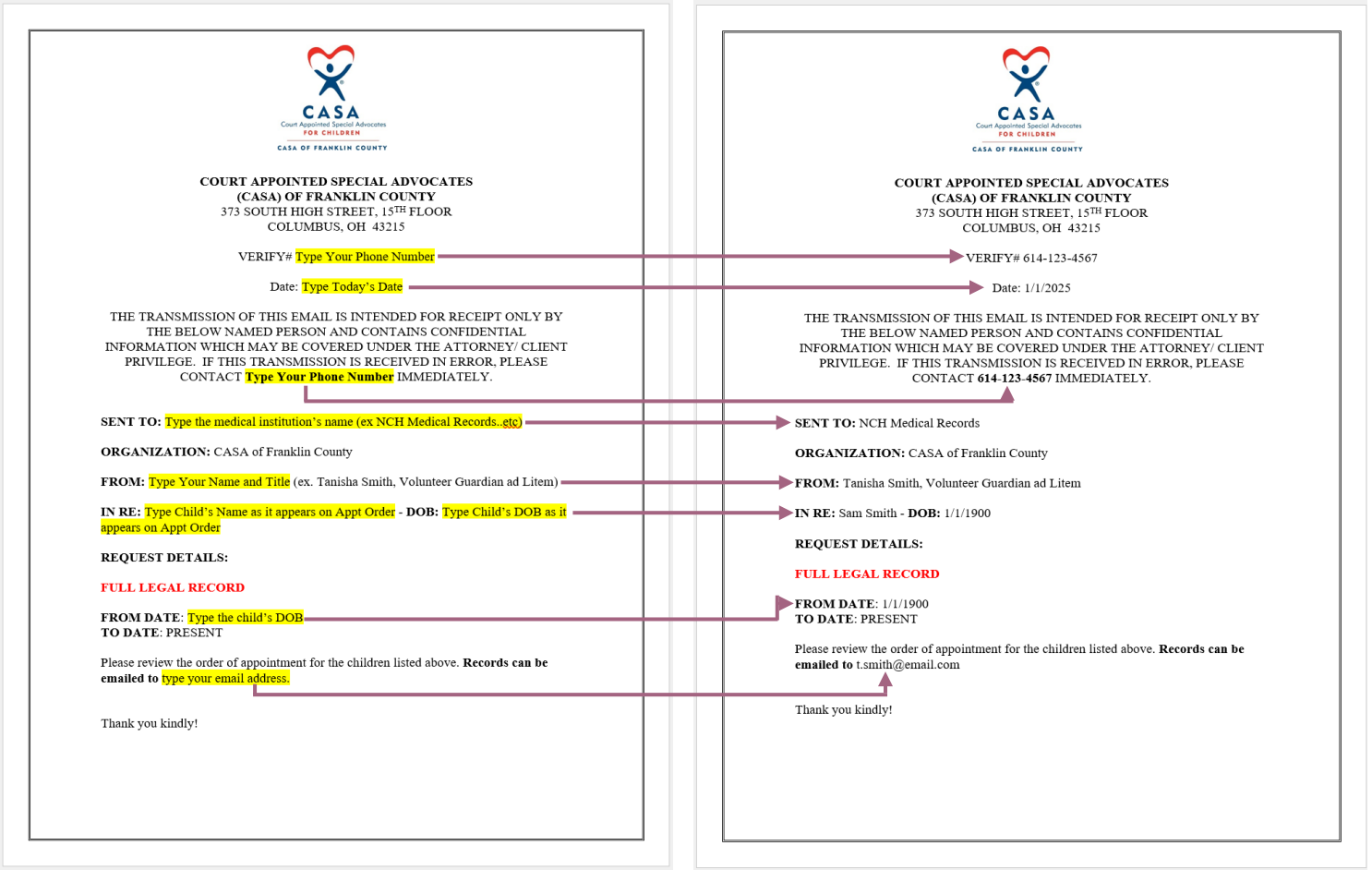
CASA
Court Appointed Special Advocates
FOR CHILDREN
CASA OF FRANKLIN COUNTY

Nationwide Children's Hospital Medical Record Request Training

Effective January 2025

NCH Request Process

1. Click the link to download the request form → CASA Medical Record Request Form
2. Navigate to the highlighted areas and add the required information:



CASA
Court Appointed Special Advocates
FOR CHILDREN
CASA OF FRANKLIN COUNTY

COURT APPOINTED SPECIAL ADVOCATES
(CASA) OF FRANKLIN COUNTY
373 SOUTH HIGH STREET, 15TH FLOOR
COLUMBUS, OH 43215

VERIFY# Type Your Phone Number

Date: Type Today's Date

THE TRANSMISSION OF THIS EMAIL IS INTENDED FOR RECEIPT ONLY BY THE BELOW NAMED PERSON AND CONTAINS CONFIDENTIAL INFORMATION WHICH MAY BE COVERED UNDER THE ATTORNEY/ CLIENT PRIVILEGE. IF THIS TRANSMISSION IS RECEIVED IN ERROR, PLEASE CONTACT **Type Your Phone Number** IMMEDIATELY.

SENT TO: Type the medical institution's name (ex NCH Medical Records..etc)

ORGANIZATION: CASA of Franklin County

FROM: Type Your Name and Title (ex. Tanisha Smith, Volunteer Guardian ad Litem)

IN RE: Type Child's Name as it appears on Appt Order - **DOB:** Type Child's DOB as it appears on Appt Order

REQUEST DETAILS:

FULL LEGAL RECORD

FROM DATE: Type the child's DOB
TO DATE: PRESENT

Please review the order of appointment for the children listed above. **Records can be emailed to** type your email address.

Thank you kindly!

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CASA OF FRANKLIN COUNTY

COURT APPOINTED SPECIAL ADVOCATES
(CASA) OF FRANKLIN COUNTY
373 SOUTH HIGH STREET, 15TH FLOOR
COLUMBUS, OH 43215

VERIFY# 614-123-4567

Date: 1/1/2025

THE TRANSMISSION OF THIS EMAIL IS INTENDED FOR RECEIPT ONLY BY THE BELOW NAMED PERSON AND CONTAINS CONFIDENTIAL INFORMATION WHICH MAY BE COVERED UNDER THE ATTORNEY/ CLIENT PRIVILEGE. IF THIS TRANSMISSION IS RECEIVED IN ERROR, PLEASE CONTACT **614-123-4567** IMMEDIATELY.

SENT TO: NCH Medical Records

ORGANIZATION: CASA of Franklin County

FROM: Tanisha Smith, Volunteer Guardian ad Litem

IN RE: Sam Smith - **DOB:** 1/1/1900

REQUEST DETAILS:

FULL LEGAL RECORD

FROM DATE: 1/1/1900
TO DATE: PRESENT

Please review the order of appointment for the children listed above. **Records can be emailed to** t.smith@email.com

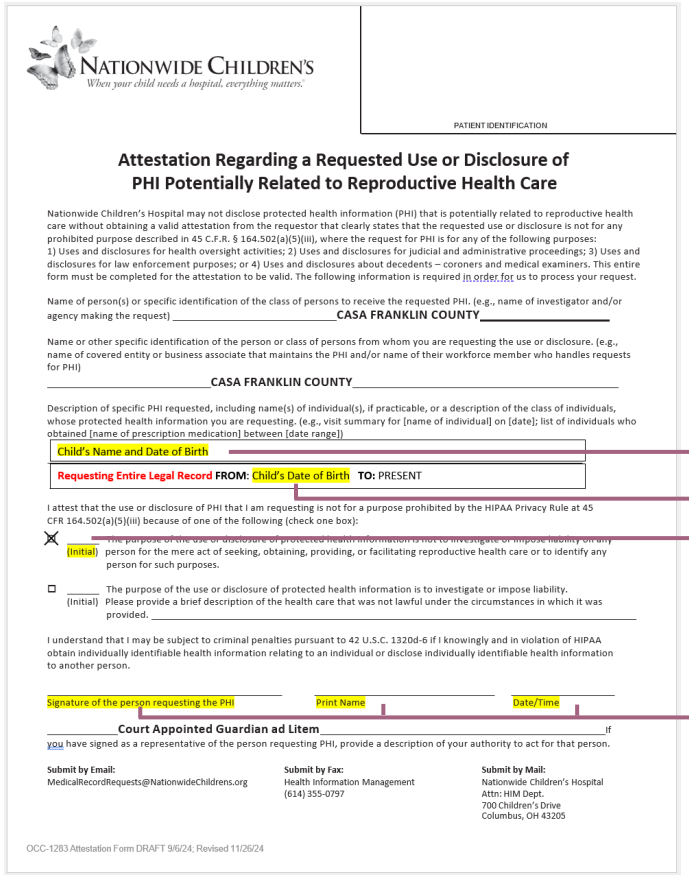
Thank you kindly!

Requesting Updated Records?

If you are sending a request for updated records, the "FROM DATE" will be the date of the last request send. For example, you sent a request on May 1st for records. In August, you want to see their medical encounters since May 1st. In the "FROM DATE" you will write "5/1/2024" to show you want records since May 1st. This ensures you do not gather their entire lifetime record again.

NCH Request Process

3. Go to CASA Resources and select the **NCH Attestation Form** from the "Request Medical Records" section
4. Navigate to the highlighted areas ONLY and add the required information:



NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.

PATIENT IDENTIFICATION

Attestation Regarding a Requested Use or Disclosure of PHI Potentially Related to Reproductive Health Care

Nationwide Children's Hospital may not disclose protected health information (PHI) that is potentially related to reproductive health care without obtaining a valid attestation from the requestor that clearly states that the requested use or disclosure is not for any prohibited purpose described in 45 C.F.R. § 164.502(a)(5)(iii), where the request for PHI is for any of the following purposes: 1) Uses and disclosures for health oversight activities; 2) Uses and disclosures for judicial and administrative proceedings; 3) Uses and disclosures for law enforcement purposes; or 4) Uses and disclosures about decedents – coroners and medical examiners. This entire form must be completed for the attestation to be valid. The following information is required in order for us to process your request.

Name of person(s) or specific identification of the class of persons to receive the requested PHI. (e.g., name of investigator and/or agency making the request) _____**CASA FRANKLIN COUNTY**_____

Name or other specific identification of the person or class of persons from whom you are requesting the use or disclosure. (e.g., name of covered entity or business associate that maintains the PHI and/or name of their workforce member who handles requests for PHI)

_____**CASA FRANKLIN COUNTY**_____

Description of specific PHI requested, including name(s) of individual(s), if practicable, or a description of the class of individuals, whose protected health information you are requesting. (e.g., visit summary for [name of individual] on [date]; list of individuals who obtained [name of prescription medication] between [date range])

Child's Name and Date of Birth

Requesting Entire Legal Record FROM: Child's Date of Birth **TO:** PRESENT

I attest that the use or disclosure of PHI that I am requesting is not for a purpose prohibited by the HIPAA Privacy Rule at 45 CFR 164.502(a)(5)(iii) because of one of the following (check one box):

☒ _____ (Initial) The purpose of the use or disclosure of protected health information is not to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care or to identify any person for such purposes.

☐ _____ (Initial) The purpose of the use or disclosure of protected health information is to investigate or impose liability. Please provide a brief description of the health care that was not lawful under the circumstances in which it was provided. _____

I understand that I may be subject to criminal penalties pursuant to 42 U.S.C. 1320d-6 if I knowingly and in violation of HIPAA obtain individually identifiable health information relating to an individual or disclose individually identifiable health information to another person.

_____ Signature of the person requesting the PHI | _____ Print Name | _____ Date/Time

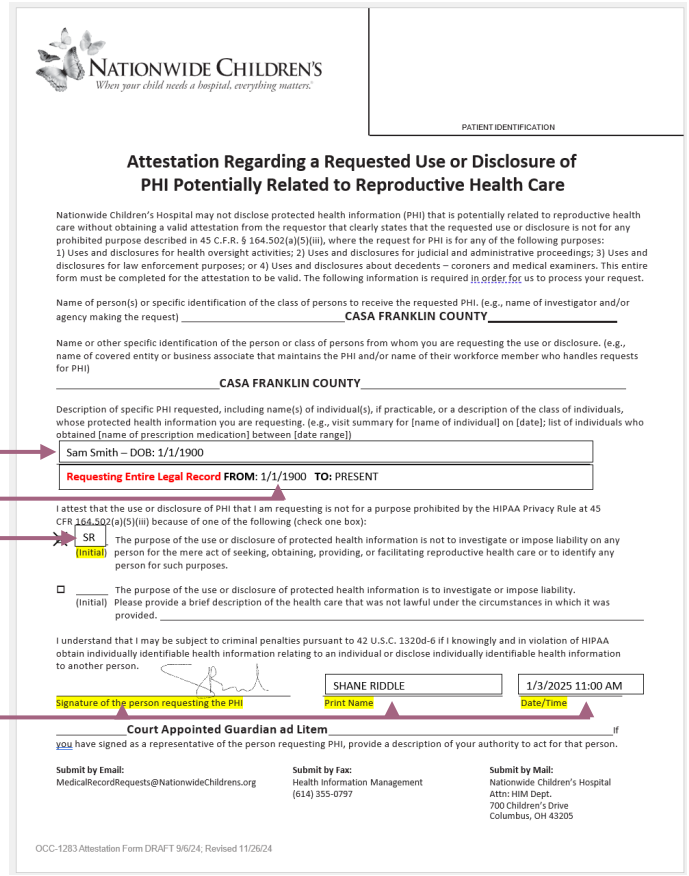
_____**Court Appointed Guardian ad Litem**_____ If you have signed as a representative of the person requesting PHI, provide a description of your authority to act for that person.

Submit by Email: MedicalRecordRequests@NationwideChildrens.org

Submit by Fax: Health Information Management (614) 355-0797

Submit by Mail: Nationwide Children's Hospital Attn: HIM Dept. 700 Children's Drive Columbus, OH 43205

OCC-1283 Attestation Form DRAFT 9/6/24; Revised 11/26/24



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Name or other specific identification of the person or class of persons from whom you are requesting the use or disclosure. (e.g., name of covered entity or business associate that maintains the PHI and/or name of their workforce member who handles requests for PHI)

_____**CASA FRANKLIN COUNTY**_____

Description of specific PHI requested, including name(s) of individual(s), if practicable, or a description of the class of individuals, whose protected health information you are requesting. (e.g., visit summary for [name of individual] on [date]; list of individuals who obtained [name of prescription medication] between [date range])

Sam Smith – DOB: 1/1/1900

Requesting Entire Legal Record FROM: 1/1/1900 **TO:** PRESENT

I attest that the use or disclosure of PHI that I am requesting is not for a purpose prohibited by the HIPAA Privacy Rule at 45 CFR 164.502(a)(5)(iii) because of one of the following (check one box):

☒ SR (Initial) The purpose of the use or disclosure of protected health information is not to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care or to identify any person for such purposes.

☐ _____ (Initial) The purpose of the use or disclosure of protected health information is to investigate or impose liability. Please provide a brief description of the health care that was not lawful under the circumstances in which it was provided. _____

I understand that I may be subject to criminal penalties pursuant to 42 U.S.C. 1320d-6 if I knowingly and in violation of HIPAA obtain individually identifiable health information relating to an individual or disclose individually identifiable health information to another person.

_____ Signature of the person requesting the PHI | SHANE RIDDLE Print Name | 1/3/2025 11:00 AM Date/Time

_____**Court Appointed Guardian ad Litem**_____ If you have signed as a representative of the person requesting PHI, provide a description of your authority to act for that person.

Submit by Email: MedicalRecordRequests@NationwideChildrens.org

Submit by Fax: Health Information Management (614) 355-0797

Submit by Mail: Nationwide Children's Hospital Attn: HIM Dept. 700 Children's Drive Columbus, OH 43205

OCC-1283 Attestation Form DRAFT 9/6/24; Revised 11/26/24

IMPORTANT:
The child's information and date range of request must match your request form or the request will be denied.

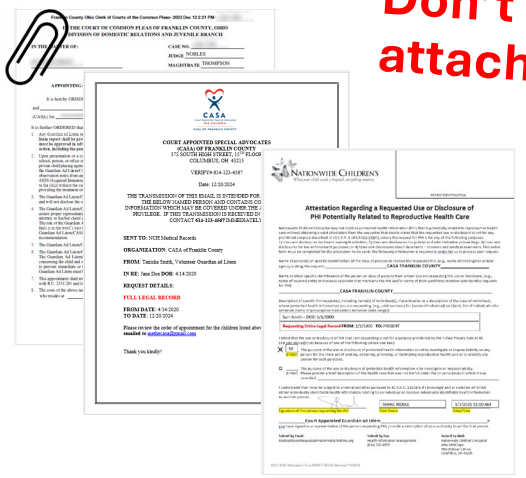
Email Template

To: medicalrecordrequests@nationwidechildrens.org
Subject: CASA Franklin County – Requesting Records
Body:

<Good Morning> <Good Afternoon> <Good Evening>,

CASA has been appointed to the Minor Child(ren) named in the attached request(s) and order(s) of appointment. Please let me know of any difficulties locating their records.

Cheers,
<Your Name, Title, Phone Number>



Don't forget your attachments!

- ❑ Copy/Paste email address
- ❑ Copy/Paste/Customize email message
- ❑ Attach the Record Request form & Attestation Form
- ❑ If a ward, attach the Order of Appointment
- ❑ If an adult or minor parent, attach the ROI
- ❑ Send **one email per child**

Planning to send requests to additional medical providers? Reach out to your Case Manager to inquire about and locate the medical provider's record request process.

Need Assistance?

Contact your case manager or email intern.rigsby@franklincountyohio.gov

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