



**CHILDREN'S MEDICAL CENTER**  
 1935 Medical District Drive • Dallas, Texas 75235  
 7601 Preston Road • Plano, Texas 75024  
 Dallas (214) 456-7000 Legacy (469) 303-7000

Medical record number: \_\_\_\_\_

Patient: \_\_\_\_\_

Date of birth: \_\_\_\_\_

ROIF  
 CMC52523-001NS Rev. 2/2009

**Authorization for the Inspection,  
 Use, Disclosure and Release of  
 Health Information**

I certify that I am the patient or legally authorized representative (e.g., mother / father) of the patient and I hereby request and authorize Children's Medical Center (Children's) to release the health information of the above named patient as follows:

**PURPOSE OF THE REQUEST / AUTHORIZATION**

- Inspect health information
- Obtain a copy of health information
- Release health information to the persons identified below

**HEALTH INFORMATION REQUESTED / AUTHORIZED**

- |   |   |
|---|---|
| <input type="checkbox"/> Discharge summary                          | <input type="checkbox"/> Doctor's orders                            |
| <input type="checkbox"/> History and physical                       | <input type="checkbox"/> Nurse's notes                              |
| <input type="checkbox"/> Progress notes                             | <input type="checkbox"/> Photographs, video, digital / other images |
| <input type="checkbox"/> Outpatient clinic visits                   | <input type="checkbox"/> Psychiatric / Psychological                |
| <input type="checkbox"/> Operative report                           | <input type="checkbox"/> Entire hospital record                     |
| <input type="checkbox"/> Labs, X-rays, pathology, EKG, EEG, CT scan | <input type="checkbox"/> Other (Specify) _____                      |

Identify date(s) of the health information requested: \_\_\_\_\_

**DISCLOSURE DETAILS**

This disclosure is made at the request of:

- Patient or legally authorized representative
- Other (Specify) \_\_\_\_\_

This health information may be disclosed to:

Name \_\_\_\_\_

Address \_\_\_\_\_

City / State / Zip \_\_\_\_\_

**SPECIALLY PROTECTED RECORDS**

I understand that if my health record contains information in reference to drug / alcohol abuse, psychiatric / mental health care, HIV / AIDS, mental retardation, or genetics testing, I agree to its release.

- I agree
- I do not agree, please specify \_\_\_\_\_

**TIME LIMIT, RIGHT TO REVOKE, RE-DISCLOSURE AND TREATMENT**

Children's is hereby released from legal responsibility or liability for the disclosure of the records to the extent indicated and authorized herein. I also understand that I may revoke this authorization in writing at any time (except to the extent that action has been taken in reliance on this authorization) by sending a written notice to the Privacy Officer, Children's Medical Center, 1935 Medical District Drive, Dallas, Texas 75235, or by faxing a written notice to the Privacy Officer at 214-456-5299.

Unless otherwise revoked, this authorization will expire 180 days from the date of my signature or as otherwise specified by an event related to the patient or the purpose of the disclosure as follows: \_\_\_\_\_

I understand that Children's may not condition treatment on my completion of this authorization form.

I understand that this health information may no longer be protected by federal and state privacy laws once it is disclosed, and, therefore, may be subject to re-disclosure by the recipient.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Patient or legally authorized representative

Relationship to patient

Printed name of patient or legally authorized representative

**IDENTITY VERIFICATION**

Identity of requestor verified via:  Photo ID  Matching signature  Other (specify) \_\_\_\_\_