CHILDREN'S HEALTH

Dallas - 1935 Medical District Drive, Dallas, Texas 75235
OCH - 1340 Empire Central, Dallas, Texas 75247
Plano- 7601 Preston Road, Plano, Texas 75024

MRN: _____
Patient: _____
Date of birth: _____

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

Return Authorization to Fax: (214) 456-6170 OR
Email: HIM-Release-of-Information.FAX@childrens.com

ROIF
CMC52523-008 Rev. 5/2021

I certify that I am the patient or legally authorized representative (e.g., parent, legal guardian) of the patient and I hereby request and authorize Children's Health 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 for the following purpose(s): ☐ Continuation of Care ☐ Personal ☐ Legal ☐ Insurance

PROTECTED HEALTH INFORMATION REQUESTED / AUTHORIZED FOR RELEASE

☐ Discharge summary
☐ History and physical
☐ Progress notes
☐ Outpatient clinic visits
☐ Alcohol / Substance Abuse Disorder Records
☐ Operative / Procedure report
☐ Reports: Labs, X-rays, pathology, EKG, EEG, CT scan
☐ Radiology images on CD
☐ Echo cath on DVD
☐ Doctor's orders
☐ Nurse's notes
☐ Photographs, video, digital / other images
☐ Psychiatric / Psychological
☐ Entire hospital record
☐ Other (Specify) _____

Covering the period of healthcare from specific date(s) _____ to _____ **OR** ☐ All past, present, and future encounters / visits
***expires in 180 days as stated below**

DISCLOSURE DETAILS

This disclosure is made at the request of: ☐ Patient or ☐ Patient's legally authorized representative.

This health information may be disclosed or released to:

_____

METHOD OF DELIVERY

☐ Mail: Address: _____ Phone Number: _____
City: _____ State: _____ Zip code: _____
☐ Fax: _____
☐ Email: _____

SPECIALLY PROTECTED RECORDS

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

☐ I agree
☐ I do not agree, please specify (include appropriate dates) _____

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

Children's Health 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 ATTN: Director Health Information Management Department, Children's Health, 1935 Medical District Drive, Dallas, Texas 75235.

I understand that Children's Health may not condition treatment, payment, enrollment or eligibility for benefits 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.

***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:** _____

_____ _____ _____
Signature of Patient or Legally Authorized Representative | Date | Time

_____ _____
Printed Name of Patient or Legally Authorized Representative | Relationship to Patient

IDENTITY VERIFICATION

Identity of requestor verified via: ☐ Photo ID ☐ Matching signature ☐ Other (specify): _____