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

ROIF
CMC52523-001NS **Rev. 7/2011**

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

Medical record number: _____

Patient: _____

Date of birth: _____

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

☐ Discharge summary
☐ History and physical
☐ Progress notes
☐ Outpatient clinic visits
☐ Operative report
☐ Labs, X-rays, pathology, EKG, EEG, CT scan
☐ Doctor's orders
☐ Nurse's notes
☐ Photographs, video, digital / other images
☐ Psychiatric / Psychological
☐ Entire hospital record
☐ 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

Time: _____

_____
Relationship to patient

_____
Printed name of patient or legally authorized representative

IDENTITY VERIFICATION

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