0 0 7 6 4

Children's Hospital of The King's Daughters Health System
601 Children's Lane, Norfolk, VA 23507-1910
Phone: (757) 668-7221
Fax: (757) 668-7625
Email: HIMRecordRelease@CHKD.org
Spanish Courtesy Line: (757) 668-9323

For Office Use Only
MRN : _____
RECEIVED DATE: _____
COMPLETED DATE: _____
USB DEVICE #: _____

Authorization To Use Or Disclose Protected Health Information

Please note that each section of this authorization must be completed in its entirety. Failure to specify, including dates, will delay the processing of this request.

PATIENT NAME (LAST NAME, FIRST NAME, MIDDLE NAME):_____

DATE OF BIRTH: _____ OTHER POSSIBLE NAMES (E.G. MAIDEN, PREFERRED):_____

I AUTHORIZE: Children's Hospital of The King's Daughters Health System, Inc. (CHKDHS) 601 Children's Lane, Norfolk, VA 23507-1910

TO DISCLOSE: (description of the health information on the patient identified above that is to be disclosed)

DESCRIPTION:	DATE:	DESCRIPTION:	DATE:
[ ] Emergency Department Record	_____	[ ] Lab Results	_____
[ ] Urgent Care Record	_____	[ ] Immunizations	_____
[ ] X-Ray Reports (does not include images)	_____	[ ] Discharge Instructions	_____
[ ] Radiology Images	_____	[ ] Mental Health Record	_____

[ ] Summarized Inpatient Record _____
(Including but not limited to: History and physical, Consults, Operative Reports, Discharge Summary, and Lab Results)

[ ] Outpatient Clinic Record (please specify clinic/department)_____ _____

[ ] Entire Legal Medical Record _____
(Including but not limited to: Consent forms, insurance ID Cards, Nurses notes, etc.)

[ ] Other: _____ _____

TO:

Recipient Name/Institution: _____ Recipient Contact Number: _____

Recipient Address (Street, City, State, Zip code):_____

Recipient Email Address:_____ Recipient Fax Number: _____

REQUEST DELIVERY: (Unless otherwise specified, request will be provided via secured electronic transmission)

CREATE PASSWORD: Please legibly print password CHKDHS will use to protect file and save for your records. Password must be a minimum of 8 characters: _____

Choose one:

[ ] Secured Email Access via Sharefile password required (accessible for 30 days) [ ] USB Drive password required (via mail)

[ ] Fax [ ] Paper Copy

FOR THE FOLLOWING PURPOSE: *The purpose is not required if the disclosure is requested by the patient.

[ ] At the request of the individual

[ ] Other (specify):_____

If the disclosure concerns substance use disorder information under the Federal Substance Abuse Confidentiality Requirements, a separate special form authorization for disclosure of substance use disorder information is required. I understand that any disclosure of health information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. **(NOTE: The recipient is prohibited from re-disclosing substance use disorder information under the Federal Substance Abuse Confidentiality Requirements without my specific written consent.)** I understand that I may revoke this authorization at any time except to the extent action has been taken in response to this authorization. I also understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Health Information Management, Children's Hospital of The King's Daughters, 601 Children's Lane, Norfolk, VA 23507-1910. (The written revocation must be legible and include the name and date of birth of the patient, the date the revocation is to go into effect, a description of the health information covered by the revocation, the person/entity no longer authorized to the receive the information, the signature of the person with legal authority for authorization/revocation, and if not the patient, a description of their legal authority for authorization/revocation, and their phone number.)

Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____.
If I fail to specify an expiration date, event, or condition, this authorization will **expire in one (1) year**.

Required if request is for the purpose of Marketing:
1. I understand that CHKDHS [ ] will [ ] will NOT receive payment as a result of using/disclosing this information.

Required if patient/legal guardian is **NOT** requesting or CHKDHS **IS** requesting the disclosure: **(check only when applicable)**
1. I understand that I may refuse to sign this authorization and that, in this instance,
   [ ] my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits.
   [ ] the law allows conditioning of treatment, payment, or my eligibility for benefits on this authorization, and the consequence of my refusal to authorize this disclosure is _____
   _____
2. **CHKDHS IS REQUIRED TO GIVE PATIENT/LEGAL GUARDIAN A COPY OF THIS AUTHORIZATION.**

I certify that I am the patient, the patient's parent or legal guardian with the authority to authorize disclosure of this patient's protected health information. I understand it can take up to thirty days to process this request and there may be a cost associated.

SIGNATURE OF PATIENT/LEGAL GUARDIAN _____ DATE_____

PRINT NAME OF PATIENT/LEGAL GUARDIAN_____ RELATIONSHIP TO PATIENT/LEGAL AUTHORITY _____