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 for Release of Records Including Substance Use Disorder 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:

[ ] Alcohol and drug documentation (Substance use) ___________________

[ ] Other: ____ ___________________

[ ] I understand that I am giving permission to disclose confidential health records that may contain behavioral health services, mental health services, and/or psychotherapy notes.

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):____

NOTICE TO RECIPIENT: 42 CFR part 2 prohibits disclosing substance use disorder information without specific written consent. I understand that I may revoke this authorization at any time except to the extent that CHKDHS has already acted in reliance on it. 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.)

A copy of this authorization shall be as effective as the original. 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.

Patient/Parent/Legal Guardian Signature (where applicable):______________________________ Date:__________

Print Name:______________________________ Relationship to Patient/Legal Authority:______________________

Witnessed by:____________________ Witness signature:______________________________Date:__________