**CHILDREN’S MEDICAL CENTER MEDICAL RECORD RELEASE AUTHORIZATION FORM**

|  |  |  |  |
| --- | --- | --- | --- |
| First Name\* | Last Name\* | Date of Birth\* | Phone Number\* |
| Address\* | City\* | State\* | Zip Code\* |

I hereby authorize the disclosure of health information about the above individual to be **released from**:

|  |  |  |  |
| --- | --- | --- | --- |
| Entity or Person\* | | | |
| Address\* | | | Telephone Number |
| City\* | State\* | Zip Code\* | Additional Information |

I hereby authorize the disclosure of health information about the above individual to be **released to**:

|  |  |  |  |
| --- | --- | --- | --- |
| Entity or Person\* | | | |
| Address\* | | | Telephone Number |
| City\* | State\* | Zip Code\* | Additional Information |

|  |
| --- |
| Reason for Disclosure\* |
| Health Information to be Disclosed\* |
| Specify time period, if desired: |

**This authorization will remain in effect until revoked or shall expire on date or event specified below.** I understand that I may revoke or cancel this authorization at any time by submitting written revocation in the manner specified by the disclosing entity, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will expire on the date or completion of the event stated below. If no date or event is specified below, this authorization will expire in one year.

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| --- |
| Expiration Date or Event: |

I understand that I may not be denied treatment, payment, and enrollment in a health plan, or eligibility of benefits for refusing to authorize disclosure unless such denial is permitted under state and federal law. I understand that information disclosed by this authorization, except as prohibited by 42 CFR Part 2 (Substance Abuse), may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule.

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| --- | --- |
| Signature of Individual\* | Date\* |
| Signature of Personal Representative (if applicable)\* (identify relationship below) | Date\* |
| Relationship of Personal Representative to Individual (Personal representative shall submit proof of authority to the disclosing entity). Please circle: Parent Legal Guardian Healthcare Power of Attorney Other (Please specify) | |