CHILDREN'S HEALTHCARE ASSOCIATES MEDICAL RELEASE POLICY

EFFECTIVE APRIL 14, 2003, THE FOLLOWING POLICY WILL BE ADHERED TO FOR ALL RELEASES OF MEDICAL INFORMATION.

1) NO MEDICAL INFORMATION WILL BE RELEASED WITHOUT WRITTEN AUTHORIZATION FROM EITHER PARENT/LEGAL GUARDIAN FOR MINOR CHILDREN UNDER 18.
2) CHILDREN OVER 18 MUST SIGN FOR THEIR OWN RECORDS.
3) ANY HIPAA PROTECTED SENSITIVE INFORMATION MAY ALSO REQUIRE THE CHILD'S SIGNATURE IF OVER 12 YEARS OLD.
4) A $15 FEE WILL BE REQUIRED FOR RECORDS REQUESTED ON DISC. $25 FEE FOR PAPER RECORDS
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CHILDREN'S HEALTHCARE WILL STORE THE <u>ORIGINAL</u> RECORDS UNTIL THE MINOR CHILD REACHES THEIR 18TH BIRTHDAY. ONLY COPIES WILL BE PROVIDED. OUR PRIVACY PRACTICES ARE POSTED IN THE MAIN LOBBY OF EACH OFFICE AND ARE AVAILABLE AS A HANDOUT.

Authorization for Release of Medical Information

Patient's name: _____ Date of Birth: _____

Address: _____

City/State/Zip Code: _____

SS#: _____ Patient's phone #: ( ) _____

Date of Request: _____ **Date Needed:** _____

Reason for request: _____

☐ I authorize _____ **to release information to:**	☐ I authorize _____ **to obtain information from:**
_____ Name of Provider or Facility	_____ Name of Provider or Facility
_____ Address	_____ Address
_____ City, State, Zip Code	_____ City, State, Zip Code
_____ Phone #/Fax # (include area code)	_____ Phone #/Fax # (include area code)

☐ Other _____
(Please describe.)

☐ Entire copy of the record checked above.

AUTHORIZATION VALID FOR: (Check one.)

☐ This request only.

☐ One year from the date of this authorization **OR** _____ . (Insert date.) This authorization applies to the records of the treatment received on or prior to the date of this authorization.

☐ This request **and** for medical records of any **future** treatment of the type described above until: _____
Insert Date

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records.

NOTE: Medical records are faxed in cases of medical necessity only.

Signature of Patient or Representative _____ Date _____

Relationship to Patient *(if requester is not the patient)* _____