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.**

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)* ______________________