Authorization to Obtain and/or Release Protected Health Information ("PHI")

This form, if signed, will authorize Cook Children's Health Care System ("CCHCS") to obtain and/or release certain health information about the person named below. All items must be completed and the authorization signed and dated by an authorized person to be valid. I may refuse to sign this authorization and I understand that CCHCS may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

1. I authorize CCHCS *(Please check all that apply)*:
   - ❑ Medical Center ❑ Physician Name/Clinic Name: _____
   - ❑ Home Health; to obtain and/or release health information, as described below, from the medical record of:

   Patient's full name: _____ DOB: _____

2. The information specified below may be obtained from and/or released to:

   _____ _____
   Name of person/organization Phone number

   _____ _____
   Address, City, State, Zip Code Fax number

3. Patient information is needed for *(Please check all that apply)*:
   - ❑ Personal use/Patient access ❑ Military ❑ Social security/Disability
   - ❑ Marketing ❑ Insurance/Billing/Claims ❑ Education
   - ❑ Continuing medical care ❑ Legal purpose ❑ Other: _____

4. Must select one: ❑ I want OR ❑ I do not want the specified information to be released to include history, diagnosis and/or treatment for: Genetics, HIV/AIDS/testing, Communicable diseases, Drugs/Alcohol, Mental Health disease.

5. Information to be released and/or obtained *(Please check all that apply)*:

   Specify dates of service: _____
   - ❑ Hospitalization reports ❑ Consultation reports ❑ Discharge summary ❑ Face sheet
   - ❑ Operative reports ❑ Emergency room record ❑ X-ray images ❑ History and physical
   - ❑ Audio, PT, OT, Speech evaluations ❑ Laboratory reports ❑ Pathology reports ❑ Progress notes
   - ❑ Radiology reports ❑ Medical information/images for marketing or education
   - ❑ Speciality Clinic Notes ❑ Other: _____

   _____ _____ _____
   Approve verbal communication with Date of visit Initials

6. I understand and acknowledge the following statements: I may be asked to show proof that I have the authority to sign this authorization. I may be charged a fee for any copies of my medical records or my child's medical records in accordance with federal and state regulations. I have the right to revoke this authorization at any time. Revocation must be made in writing to: ***Cook Children's Health Care System, Health Information Management Department, 801 7th Avenue, Fort Worth, Texas 76104.*** My revocation will not apply to information that has already been disclosed in response to this authorization. After the above medical information is released, it may be re-released by the recipient and the information may no longer be protected by federal privacy laws or regulations.
   REVOCATION: Unless otherwise revoked in writing, this authorization is valid until the following specific date (optional): Month _____ Day _____, Year _____. For patients under the age of 18 at the time this authorization is signed, if no expiration date is indicated, this authorization is valid until the patient's 18th birthday. For patients who are 18 years of age or older at the time this authorization is signed, if no expiration date is indicated, this authorization will expire 2 years from the date this form is signed.

7. _____ _____ _____ _____
   Patient/Parent/Legally Authorized Representative Signature Patient/Parent/Legally Authorized Representative Printed Name Date Time

8. _____
   Relationship to patient

PRINT OR IMPRINT PATIENT INFORMATION

Cook Children's

801 7th Avenue
Fort Worth, Texas 76104-2796

CSN _____

MRN _____