0 0 7 6 4

Children's Hospital of The King's Daughters Health System
601 Children's Lane, Norfolk, VA 23507-1910

MR #:

Authorization To Use Or Disclose Protected Health Information

PATIENT NAME:	DATE OF BIRTH:

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)

[ ] the shot/immunization records

[ ] any and all of the medical records pertaining to the treatment of the patient seen in the hospital or clinic on or about _____ 20_____.

[ ] specify:_____

_____

TO: Name/Institution:_____

Address:_____

City/State, Zip: _____

Fax Number:_____

FOR THE FOLLOWING PURPOSE: [ ] At the request of the individual [ ] Other (specify): _____

_____

NOTE: The purpose is not required if the disclosure is requested by the patient unless the disclosure concerns substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that any disclosure of health information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. **(NOTE: The recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.)**

I understand that I may revoke this authorization at any time except to the extent action has been taken in response to this authorization. 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.)

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.

_____ _____
SIGNATURE OF PATIENT/LEGAL GUARDIAN DATE

_____
RELATIONSHIP TO PATIENT/LEGAL AUTHORITY