0 2 6 4 4

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

MR #:

Adult Patient's Authorization for CHKDHS to Disclose Protected Health Information to Parents

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 **at the request of a parent)**

CHECK ALL THAT APPLY

- ☐ through discussion, the patient's health and health care treatment.
- ☐ any and all of the **medical records** pertaining to the treatment of the patient seen in the hospital or clinic.
- ☐ any and all of the **bills/billing statements** pertaining to the treatment of the patient seen in the hospital or clinic.
- ☐ any and all of the **medical records** pertaining to the treatment of the patient seen in the hospital or clinic on or about _____ 20_____.
- ☐ any and all of the **bills/billing statements** pertaining to the treatment of the patient seen in the hospital or clinic on or about _____ 20_____.
- ☐ Other specify:_____

_____

TO: My Parent(s): Mom_____ Dad_____

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.)

This authorization will expire when I reach the age of 27 years unless otherwise revoked or specified here:
_____.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits.

I certify that I am the patient with the authority to authorize disclosure of my protected health information.

_____ _____
SIGNATURE OF PATIENT/LEGAL GUARDIAN DATE

_____
RELATIONSHIP TO PATIENT/LEGAL AUTHORITY

CHKD Form 2644 MR 1/14 **CHKDHS IS REQUIRED TO GIVE PATIENT/LEGAL GUARDIAN A COPY OF THIS AUTHORIZATION**

Original- Medical Record Copy- Patient/Legal Guardian