0 0 7 6 4

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

MR #:

Radiology Authorization To Use Or Disclose Protected Health Information

PATIENT NAME:	DATE OF BIRTH:

I AUTHORIZE: Radiology at Children's Hospital of The King's Daughters Health System, Inc.(CHKDHS)

TO DISCLOSE: (description of the health information on the patient identified above that is to be disclosed)

☐ Radiological Digital Images:

Type of image: _____ Image Date: _____

Type of image: _____ Image Date: _____

Type of image: _____ Image Date: _____

Type of image: _____ Image Date: _____

Type of image: _____ Image Date: _____

Type of image: _____ Image Date: _____

☐ Radiology Report for the above listed exams

☐ Other (specify): _____

NOTE: If the images provided by CHKDHS contain images obtained by another facility, CHKD cannot verify their authenticity. CHKDHS recommends contacting the other facility to obtain their complete records on this patient.

TO: Name/Institution: _____

Address: _____

City/State, Zip: _____

Fax Number: _____

FOR THE FOLLOWING PURPOSE: ☐ To provide to another Facility (specify): _____

☐ 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 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