AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

This form, if signed, will authorize Cook Children's Northeast Hospital (CCNH) to use and disclose 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 understand this authorization is voluntary, I may refuse to sign this authorization and I understand that CCNH may not withhold treatment because I refuse to sign this authorization.

1. I authorize CCNH to disclose health information, as described below, from the medical record of :

   Patient's Full Name: _____ Date of Birth:_____

2. The information specified below may be released to:

   Name/Company:_____

   Address:_____ Telephone:_____

   City:_____ State:_____ Zip:_____

3. The specific purpose(s) for this disclosure is/are [check (✓) your selection]: ❑ my personal records; ❑ share with other healthcare providers ❑ Other (please describe);_____

4. _____I WANT _____I DO NOT WANT [check (✓) your preference] the specified information to be released to include history, diagnosis and/or treatment for: HIV/AIDS/testing, Communicable diseases, Drugs/Alcohol, Mental Health disease.

5. SPECIFY EXACT INFORMATION TO BE RELEASED: (1) Place a check (✓) next to the specific medical information to be released, (2) list the specific dates of treatment;

✓	INFORMATION	DATES OF SERVICE	✓	INFORMATION	DATES OF SERVICE
___	Discharge Summary	_____	___	Operative Report(s)	_____
___	History & Physical	_____	___	ED/ER Report(s)	_____
___	Consultation Report(s)	_____	___	Urgent Care Report(s)	_____
___	Imaging Report(s)	_____	___	Inpatient Report(s)	_____
___	Imaging CD	_____	___	Billing Record(s)	_____
___	Other (please specify)	_____			

6. **I understand and acknowledge the following statements:** I may be asked to show proof that I have the authority to sign an authorization to review, receive or release to another party copies of the above named patient's medical record which I am requesting. In order to inspect or receive a copy of a copy of the medical record for myself, I must complete and sign this authorization form. If I request to do so, I may inspect the medical information to be released to another party after signing this form. Unless required or allowed by law, the medical information will not be released to another party, if, after inspecting the medical information, I revoke this authorization prior to the release of the medical information. 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. A facsimile or photocopy of this authorization is as valid as the original. I will be charged a fee for any copies of my medical records or my child's medical record I request for myself or for use by others. Fees for copies are due and payable before copies are released. I may revoke this authorization at any time by notifying CCNH in writing to **ATTN**: Cook Children's Northeast Hospital, Health Information Department (i.e. Medical Records Dept.), of my intent to revoke this authorization, except that if I do notify CCNH in writing of my intent to revoke this authorization, such revocation will not have any affect on any actions by CCNH taken before the revocation. Unless otherwise revoked in writing, this authorization will EXPIRE 180 DAYS from the date this form is signed.

7. _____ _____ _____
   Date | Signature of Patient, Parent or Legally Authorized Representative | Relationship to Patient

8. _____ _____
   Printed Name of Parent or Legally Authorized Representative | Patient ID# (Office use only)

NOTE: All items in this authorization must be completed to be valid and executable

ROI

Cook Children's

Northeast Hospital
6316 Precinct Line Rd
Hurst, Texas 76054

Patient Label/ Information Here

Cook Children's
Northeast Hospital

PATIENT GUIDE TO RELEASE OF MEDICAL RECORDS

How to Get Authorization

To request a copy or have a copy of the medical record sent to another party, call Cook Children's Northeast Hospital's Health Information Management Department at 817-605-2984 between the hours of 8:00a.m. and 5:00 p.m., Monday through Friday. If you cannot print the authorization form from our website, we will be happy to mail, fax or email you a form.

Who Must Authorize Release of Information

Parents or legal guardians (without court imposed restrictions) may obtain and/or authorize the release of protected health information from their child's Cook Children's Northeast Hospital's medical record. Individuals 18 or older must authorize the release of their own information.

Written Authorization: What to Do

1. Carefully read the authorization form.
2. Provide all requested information.
3. Be very specific about the information you need released. Write down date, types of visits, and what parts of the record you need. (if you do not know specific dates of service a date range can be used: For example month & year or just year)
4. For imaging reports (i.e. x-rays, ultrasounds, MRI, etc.) please check the box on the form that you need imaging reports.
5. Sign and date the authorization using your full legal signature.
6. Please remember, we will return the form to you if any information is missing or incomplete. This may delay the release of information.
7. Mail completed authorization form to;

Attention: HIM Medical Record Release
Cook Children's Northeast Hospital
6316 Precinct Line Rd
Hurst, Texas, 76054
or
Fax to 817-605-2985.

Before Releasing a Record

Picking up copy of record(s) - You must provide a valid current government issued picture identification card when picking up records from our office.

Request copy of record(s) be mailed - You must provide a legible copy of a valid current government issued picture identification card (i.e. Driver License, passport, etc.) along with the completed Authorization form when records are requested to be mailed from our office.

Fee for Release

There is a fee for release of copied medical records. This fee must be paid at the time of, or before the release is completed.

Time for Release

Because of the number of requests we receive, it may take up to 15 business days to process a request. If you plan on picking up the records, please call ahead of time to ensure they are ready when you arrive.

If you have any questions related to any of the above, please contact HIM at 817-605-2984.

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