CHILDREN'S HEALTH

ROIF
CMC72221-001NS Rev. 10/2016

Authorization for Use or Disclosure of Protected Health Information

I certify that I am the patient, that I am 18 years of age or older, and that I request and authorize Children's Health to release my health information as follows:

Authorization

I authorize Children's Health to use and disclose the protected health information described herein to the below named individuals:

Name: _____ Name: _____

Effective Period

This authorization for release of information is for healthcare that was provided to me (Check applicable box):

☐ From _____ (date) to _____(date)

☐ All past, present, and future periods.

Health Information Authorized

☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, treatment of alcohol or drug abuse, and heritable genetic information).

☐ I authorize the release of my complete health record with the exception of the following information:

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol / drug abuse treatment
- ☐ Heritable genetic information
- ☐ Other (please specify): _____

Time Limit, Right to Revoke, Re-Disclosure, and Treatment

Children's Health is hereby released from legal responsibility or liability for the disclosure of the health information to the extent indicated and authorized herein. I understand that a revocation is not effective to the extent that Children's has already acted in reliance on my authorization. I also understand that I may revoke this authorization in writing at any time (except to the extent that action has been taken in reliance on this authorization) by sending a written notice to: Children's Health; Attention Privacy Officer; 1935 Medical District Drive, Dallas, Texas 75235.

Unless otherwise revoked, this authorization will expire 3 years from the date of my signature.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

By signing this authorization, I acknowledge that I have read and understand the statements contained herein.

_____ _____ _____

Signature of Patient Date Time

_____

Printed Name