


**The Children's Hospital
of Philadelphia®**

 MR-109
AEL 9/2005

**AUTHORIZATION TO RELEASE/OBTAIN
PATIENT INFORMATION**

NAME _____

SEX M F

MR# _____

AGE / DATE OF BIRTH _____

ACCOUNT# _____

(PATIENT PLATE OR PRINT)

This authorizes The Children's Hospital of Philadelphia and its affiliates to release/obtain information as described below. For a listing of related entities and medical practices, see The Children's Hospital of Philadelphia *Notice of Privacy Practices*.

- 1. Patient Name (First, Middle, Last):** _____
Address of Patient: _____
City, State, Zip: _____
Telephone Number: _____ **Date of Birth:** _____
- 2. What is the name of the person or facility that will be releasing your information?** Check the appropriate box below and provide the name, address and telephone number of the person/facility releasing the information.
 The Children's Hospital of Philadelphia or **Other**
 Name of Person / Facility: _____
 Address: _____
 City, State, Zip: _____
 Telephone Number: _____ Fax Number: _____
- 3. What information will be released?** Date of appointment or hospital stay beginning _____ through to _____
 Emergency Department **Home Care** **Outpatient**
 Inpatient **Immunization** (please specify name of department/office)
 Other Information (please specify) _____
 If there is any part of the record you do not wish released, please indicate here: _____
 If your records contain any information about substance (drug or alcohol) abuse, HIV, or mental health, may this information be released? If yes, please initial next to each type of information to be released:
Drug and/or alcohol treatment or testing _____ **HIV** _____ **Mental Health** _____
- 4. What is the name of the person or facility who is to receive your information?** Check the appropriate box below and provide the name, address and telephone number of the person/facility receiving the information.
 The Children's Hospital of Philadelphia or **Other**
 Name of Person / Facility: _____
 Address: _____
 City, State, Zip: _____
 Telephone Number: _____ Fax Number: _____
- 5. Please explain why the person or facility above needs this information:**

- 6. Expiration.** Your permission will expire 90 days after you sign this form unless you indicate otherwise. If you would like to extend your permission for longer than 90 days, please tell us when your permission expires. The date cannot be more than a year from now: _____
- 7. Understanding this Authorization**
 - This allows the release or obtaining of information that exists in the patient's medical record when the form is signed, as well as information created after the form is signed until it expires.
 - I may withdraw my permission at any time by providing written notice to the above-named provider releasing the information. For information being released by The Children's Hospital of Philadelphia, see its *Notice of Privacy Practices* for instructions on how to withdraw (revoke) an authorization. If I withdraw my permission, any information that was already released cannot be retrieved.
 - Information released by The Children's Hospital of Philadelphia may be released again by the person or organization that receives it and is no longer protected under federal privacy laws. The Children's Hospital of Philadelphia will protect information it obtains as required by federal privacy laws.
 - I understand my permission is voluntary and I/my child will receive treatment whether or not I sign this form.
- 8. Signature.** By signing, I understand that I am authorizing The Children's Hospital of Philadelphia to release/obtain information as described above.

Signature _____

Print Name _____

Date _____

 Relationship to patient: Patient Parent Legal Guardian Other: _____

Information Released by: _____ Date: _____