

1. I hereby authorize Driscoll Children's Hospital to release information from the health care record (s) of:
 Patient name: _____ DOB: _____ Sex: _____
 Address: _____
 Social Sec.#: _____ Guardian: _____
 Mother: _____ Father: _____

2. Information to be released is for the date(s) of service from (date): _____ to (date) _____
 3. Treating physician while at Driscoll: _____
 4. Information is to be released to: Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone # (including area code): _____ Fax#: _____

5. Purpose of release (please initial):
 Attorney Physician office/Clinic Personal use (fee for copies)
 Child Protective Services/Law Enforcement Children's Advocacy Center and/or related services
 Other (please explain): _____

6. Type of information to be released: **DO NOT CHECK EVERY BOX IF COMPLETE RECORD NEEDED. SEE FIRST BOX.**

<input type="checkbox"/> Complete health record	<input type="checkbox"/> Operative report and pathology report	<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> History and physical exam	<input type="checkbox"/> Consultation report	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Laboratory test results	<input type="checkbox"/> Radiology reports	<input type="checkbox"/> Psychiatric notes
<input type="checkbox"/> Medical Forensics Exam Record	<input type="checkbox"/> Emergency department record	<input type="checkbox"/> Outpatient clinic note
<input type="checkbox"/> Abstract of health record	<input type="checkbox"/> Face sheet	<input type="checkbox"/> Radiology films
<input type="checkbox"/> Other, please specify: _____		<input type="checkbox"/> Billing records

7. **TIME LIMIT AND RIGHT TO REVOKE AUTHORIZATION:** Except to the extent that action that has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the Record Custodian at Driscoll Children's Hospital. Unless revoked, this authorization will expire on the following date or event (*fill in date or event*) _____ or 180 days from the date of signature.

8. I further authorize that a photocopy of this authorization form will be fully acceptable as an original.

9. The facility, its employees, officers, and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

10. **DRUG AND/OR ALCOHOL ABUSE, AND/OR PSYCHIATRIC, AND/OR HIV/AIDS RECORDS RELEASE:** I understand the information could contain references to, or results of psychological and/or psychiatric impairment, substance abuse, sexual assault, physical abuse, or AIDS/ARC antibody testing (Acquired Immune Deficiency Syndrome/AIDS Related Complex, HIV Antibody Testing).

11. Pre-payment of copies is required except in the case of a medical emergency or continuity of care

12. I understand that Driscoll Children's Hospital may not condition treatment, payment, enrollment or eligibility of benefits based on my completion of this authorization form.

RE-DISCLOSURE: This information is being disclosed to you from confidential records and confidentiality is protected by Federal Law 42 C.F.R., Part 2. You are prohibited from making any further disclosure of information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of information of medical or other information is not sufficient for this purpose.

Signature of Patient, Guardian, or Authorized Representative

Date

Relationship to patient

Phone #

Witness

Driscoll Children's Hospital
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 Corpus Christi, Texas 78411
 (361) 694-5468