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.**

☐ Complete health record	☐ Operative report and pathology report	☐ Discharge Summary
☐ History and physical exam	☐ Consultation report	☐ Progress Notes
☐ Laboratory test results	☐ Radiology reports	☐ Psychiatric notes*
☐ Medical Forensics Exam Record	☐ Emergency department record	☐ Outpatient clinic note
☐ Abstract of health record	☐ Face sheet	☐ Radiology films
☐ Other, please specify:		☐ 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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(361) 694-5468