CHILDREN'S MEDICAL CENTER

Medical record number: _____

Patient: _____

Date of birth: _____

ROIF
CMCOnline **Rev. 10/2012**

Request for Release of Protected Health Information

I certify that I am the patient or legally authorized representative (e.g., mother / father) of the patient and I hereby request that the following protected health information be released for treatment purposes:

HEALTH INFORMATION REQUESTED / AUTHORIZED

- ☐ Discharge summary
- ☐ History and physical
- ☐ Progress notes
- ☐ Outpatient clinic visits
- ☐ Operative report
- ☐ Labs, X-rays, pathology, EKG, EEG, CT scan
- ☐ Doctor's orders
- ☐ Nurse's notes
- ☐ Photographs, video, digital / other images
- ☐ Psychiatric / Psychological
- ☐ Entire hospital record
- ☐ Other (Specify) _____

Identify date(s) of the health information requested: _____

SPECIALLY PROTECTED RECORDS

I understand that if my health record contains information in reference to drug / alcohol abuse, psychiatric / mental health care, HIV / AIDS, mental retardation, or genetics testing, I agree to its release.

☐ I agree ☐ I do not agree, please specify _____

The requested health information may be released from facility stated below to Children's Medical Center:

	Release records from:	Send records here:
Name:		☐ Dallas Campus 1935 Medical District Drive Dallas, TX 75235 ☐ Legacy Campus 7601 Preston Road Plano, TX 75024
Address:		
Telephone Number:		
Fax Number:		

I understand that federal laws and regulations do not require an authorization for release of protected health information for treatment purposes. This form is to provide a formalized written manner of communication for requesting protected health information from one health care provider to another.
Unless otherwise revoked, this authorization will expire 180 days from the date of my signature or as otherwise specified by an event related to the patient or the purpose of the disclosure as follows: _____

Date: _____

Time: _____

Signature: _____
Patient or legally authorized representative

_____
Relationship to patient

_____
Printed name of patient or legally authorized representative

IDENTITY VERIFICATION

Identity of requestor verified via: ☐ Photo ID ☐ Matching signature ☐ Other (specify) _____