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Children's Hospital of The King's Daughters Health System (CHKDHS) Inc.
601 Children's Lane, Norfolk, VA 23507-1910

Authorization for CHKDHS to Obtain and/or Exchange Protected Health Information

PATIENT NAME:	DATE OF BIRTH:

I AUTHORIZE: Name: _____ Address: _____

☐ TO DISCLOSE ☐ TO RECEIVE ☐ TO DISCLOSE & RECEIVE the following information on the above-mentioned patient.

- ☐ Immunization and/or Physical Examination records
- ☐ All medical records pertaining to the treatment of the patient seen in the hospital or clinic during the following period: _____ to _____
- ☐ Specific document(s): _____

TO/FROM: Children's Hospital of The King's Daughters Health System, Inc. (CHKDHS)

Address: _____ Fax Number: _____
_____ Phone Number: _____

FOR THE FOLLOWING PURPOSE: ☐ Continuity of Care ☐ Other (specify): _____

If any disclosure by CHKD concerns substance use disorder information under the Federal Substance Abuse Confidentiality Requirements, a separate authorization form for disclosure of substance use disorder information is required. I understand that any disclosure of health information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. **()** I understand that I may revoke this authorization at any time except to the extent action has been taken in response to this authorization. I also understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Health Information Management, Children's Hospital of The King's Daughters, 601 Children's Lane, Norfolk, VA 23507-1910. (The written revocation must be legible and include the name and date of birth of the patient, the date the revocation is to go into effect, a description of the health information covered by the revocation, the person/entity no longer authorized to the receive the information, the signature of the person with legal authority for authorization/revocation, and if not the patient, a description of their legal authority for authorization/revocation, and their phone number.)

Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____.

If I fail to specify an expiration date, event, or condition, this authorization will **expire in one (1) year**.

Required if request is for the purpose of Marketing:

1. I understand that CHKDHS ☐ will ☐ will NOT receive payment as a result of using/disclosing this information.

Required if patient/legal guardian is **NOT** requesting or CHKDHS **IS** requesting the disclosure: **(check only when applicable)**

1. I understand that I may refuse to sign this authorization and that, in this instance, my refusal to sign ☐will ☐will NOT affect my ability to obtain treatment, payment, or my eligibility for benefits.
   ☐ the law allows conditioning of treatment, payment, or my eligibility for benefits on this authorization, and the consequence of my refusal to authorize this disclosure is _____
   _____
2. I may inspect or copy any information used/disclosed under this authorization.
3. **CHKDHS IS REQUIRED TO GIVE PATIENT/LEGAL GUARDIAN A COPY OF THIS AUTHORIZATION.**

I certify that I am the patient, the patient's parent or legal guardian with the authority to authorize disclosure of this patient's protected health information. I understand that I am giving permission to disclose confidential health records that may contain behavioral health services **and** mental health services. **A minor's signature (14 years old and older) is required to release the following information: reproductive care, sexually transmitted diseases, and mental health treatment**

SIGNATURE OF PATIENT/LEGAL GUARDIAN _____ DATE_____

PRINT NAME OF PATIENT/LEGAL GUARDIAN_____RELATIONSHIP TO PATIENT/LEGAL AUTHORITY _____