



Children's Hospital of The King's Daughters Health System
601 Children's Lane, Norfolk, VA 23507-1910

FOR CHKD OFFICE USE ONLY:
Medical Record #:

Authorization To Use Or Disclose Protected Health Information-SMPT Community Outreach Services

PARTICIPANT NAME: (PLEASE PRINT)	DATE OF BIRTH:
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I AUTHORIZE: Children's Hospital of the King's Daughters Health System (CHKDHS)
601 Children's Lane, Norfolk, VA 23507-1910

TO DISCLOSE: Information about services provided by Sports Medicine Physical Therapy staff and/or the condition of the participant identified above as related to sports activities.

TO: _____

FOR THE FOLLOWING PURPOSE: At the request of the individual

NOTE: The purpose is not required if the disclosure is requested by the patient.

If the disclosure concerns substance use disorder under the Federal Substance Abuse Confidentiality Requirements, a separate authorization 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. (NOTE: The recipient may be prohibited from re-disclosing substance use disorder information under the Federal Substance Abuse Confidentiality Requirements without my specific written consent.)

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 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.**

I understand that I may refuse to sign this authorization and that, in this instance; my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits.

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.

PRINT NAME OF PATIENT/LEGAL GUARDIAN

SIGNATURE OF PATIENT/LEGAL GUARDIAN

DATE

RELATIONSHIP TO PATIENT/LEGAL AUTHORITY