



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

MR #: _____

Authorization To Use Or Disclose Protected Health Information

PATIENT NAME: _____	DATE OF BIRTH: _____
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I AUTHORIZE: Children's Hospital of The King's Daughters Health System, Inc.(CHKDHS)
601 Children's Lane, Norfolk, VA 23507-1910

TO DISCLOSE: (description of the health information on the patient identified above that is to be disclosed)

- the shot/immunization records
- any and all of the medical records pertaining to the treatment of the patient seen in the hospital or clinic on or about _____ 20_____.
- I understand that I am giving permission to disclose confidential health records that may contain behavioral health services, mental health services, and/or psychotherapy notes.
- specify: _____

TO: Name/Institution: _____
Address (Street, City, State, Zip Code): _____
Contact Phone Number: _____
Email Address: _____
Fax Number: _____

FOR THE FOLLOWING PURPOSE: At the request of the individual Other (specify): _____

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

If the disclosure concerns substance use disorder information under the Federal Substance Abuse Confidentiality Requirements, a separate special form 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 is 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.**

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 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. 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.

SIGNATURE OF PATIENT/LEGAL GUARDIAN _____ DATE _____

PRINT NAME OF PATIENT/LEGAL GUARDIAN _____ RELATIONSHIP TO PATIENT/LEGAL AUTHORITY _____