



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 treatment for alcohol and drug abuse.

specify: \_\_\_\_\_  
\_\_\_\_\_

TO: Name/Institution: \_\_\_\_\_

Address: \_\_\_\_\_

City/State, Zip: \_\_\_\_\_

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 unless the disclosure concerns substance abuse information under the Federal Substance Abuse Confidentiality Requirements.**

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 disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.)

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

\_\_\_\_\_  
RELATIONSHIP TO PATIENT/LEGAL AUTHORITY