Texas Children's Hospital
Integrated Delivery System

Authorization for Release of Protected Health Information to Texas Children's Hospital

This completed form authorizes a third party to disclose or release a patient's protected health information to TCH.

I. Patient's Name: _____ Birth Date: _____

Patient's Address: _____ Home Phone: _____

City, State, Zip: _____ Dates of Service: _____

II. Check the reports to be disclosed:

( ) Abstract - includes Face Sheet, Discharge Summary, History and Physical Exam, Operative and Pathology Reports, Consultation Reports, Radiology Reports and EEGs

Or:

( ) Discharge Summary
( ) History and Physical Exam
( ) Consultation Reports
( ) Progress Notes
( ) Radiology Reports
( ) Laboratory Reports
( ) Pathology Reports
( ) Operative Reports
( ) Clinic/Outpatient Record
Which clinic or Dr? _____
( ) Billing Claims Forms
( ) Itemized Statement of Charges
( ) Other, specify: _____
( ) All Information

Or, for mental health records (May require physician/psychologist approval):

( ) Psychiatric/Mental Health Records ( ) LSC/CAP Records ( ) Neuropsychological Testing
( ) Other, specify: _____ ( ) All information

III. Records released from: Name _____ Phone: _____

Mailing Address: _____ Fax: _____

IV. Records released to: Name _____ Phone: _____

Mailing Address: _____ Fax: _____

V. For the purpose of: _____

VI. I authorize the third party named in Section III above to disclose the protected health information about myself (or the patient) as described above to TCH as provided in Section IV above. I understand:

- This authorization expires 180 days from the date of my signature unless I specify otherwise.
  Expiration: _____
- I may revoke this authorization at any time by notifying TCH in writing. If I revoke the authorization I understand that it will have no affect on actions TCH took in good faith before receiving the revocation.
- The information released may contain information related to AIDS or HIV infection; drug or alcohol abuse; mental or behavioral health or psychiatric care, except for psychotherapy notes.
- TCH reserves the right to verify my identity/guardianship.
- I will be charged for the copies requested.
- I understand that TCH may not condition treatment or payment on my completion of this form.

Signature: _____ Date _____

Printed Name: _____ Relationship to Patient: _____

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