

THE HSC PEDIATRIC CENTER
REQUEST AND AUTHORIZATION TO RELEASE, USE AND/OR SHARE MEDICAL INFORMATION

1. Patient Information and Statement:

I give my authorization/permission for the HSC Pediatric Center to release, use and/or share the medical information described below. I understand that this permission is voluntary. I also understand that once this information is released, used and/or shared, the person or organization that received it may share it again. If this happens, the information may no longer be protected under applicable privacy laws. I understand the type of information that is being released, used and/or shared and how this will be done.

Patient Name (first, middle, last) _____
 Patient Address: _____

 Telephone # _____
 Patient Date of Birth _____ MR# _____

2. Records that may be released, used and/or shared: Please indicate below the section(s) of the record that you would like released or that you permit us to use and/or share:

<input type="checkbox"/> History and Physical (IAAF) Exam Date(s) of service _____	<input type="checkbox"/> Discharge Summaries Date(s) of service _____
<input type="checkbox"/> Immunization Records Date(s) of service _____	<input type="checkbox"/> Complete Medical Record Date(s) of service _____
<input type="checkbox"/> Outpatient Records Date(s) of service _____	<input type="checkbox"/> Consultation Reports Date(s) of service _____
<input type="checkbox"/> Progress Notes Date(s) of service _____	<input type="checkbox"/> Laboratory Tests Date(s) of service _____
<input type="checkbox"/> Radiology Reports Date(s) of service _____	<input type="checkbox"/> Other Records Date(s) of service _____

✳ If the medical record contains any of the following sensitive information, HSC Pediatric Center will only release these records if your initials are next to that type of information listed below.
Drug and/or alcohol treatment or testing _____ HIV information _____
Mental/Behavioral health information _____ (a separate release is required for notes taken during psychotherapy sessions).

3. Agency/Person requested information should be released to (please include address):

Agency/Person _____
 Address _____

 Telephone # _____ Fax # _____

4. Time Frame: What is the time limit for this authorization? _____ **✳ Time limit cannot be greater than 180 days from date of request**

5. What is the reason for releasing, using and/or sharing this information?

The information will be released, used and/or shared for these specific reasons: _____

I understand that I may revoke (withdraw) my permission at any time. If I wish to withdraw my permission, I must put this request in writing and send it to:

The Director of Health Information Management
 The HSC Pediatric Center
 1731 Bunker Hill Rd. NE
 Washington, DC 20017

I understand that if I send a letter withdrawing my permission, that letter cannot bring back any information that was already released, used and/or shared. I also understand that it will take time for the HSC Pediatric Center to receive and process my request.

Signature of Patient/Parent/Legal Guardian _____ Date _____

If a person cannot provide a written signature, two witnesses must sign:

Witness _____ Date _____
 Witness _____ Date _____

Submit to request:
 The Department of Health Information Management
 The HSC Pediatric Center
 1731 Bunker Hill Rd. NE
 Washington, DC 20017