PATIENT NAME: _____ Date of Birth: _____

ADDRESS: _____ TELEPHONE: _____

I certify that I am the patient or legally authorized representative (e.g. mother/father/legal guardian) of the patient and I hereby request and authorize EL PASO CHILDREN'S HOSPITAL, 4845 Alameda Ave, El Paso, Texas, 79905 to disclose the medical record information and/or protected health information (PHI) of the patient as follows:

PURPOSE OF THE REQUEST / AUTHORIZATION

- ☐ Legal
- ☐ Personal
- ☐ Release health information to the persons identified below

HEALTH INFORMATION REQUESTED / AUTHORIZED

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Progress Notes
- ☐ Consultation
- ☐ Outpatient clinic visits
- ☐ Operative Report
- ☐ Labs, Pathology
- ☐ X-Rays, EKG, EEG, CT scan, MRI
- ☐ Doctor's Orders
- ☐ Nurse's Notes
- ☐ Photographs, video, digital / other images
- ☐ Psychiatric / Psychological
- ☐ Rehabilitation
- ☐ Pertinent Information
- ☐ Entire Hospital Record
- ☐ Other (Specify) : _____

Identify date(s) of the health information requested: _____

DISCLOSURE DETAILS

This disclosure is made at the request of:

- ☐ Patient or legally authorized representative
- ☐ Other (Specify)

The health information may be disclosed to:

Name : _____

Address: _____

City / State / Zip: _____

SPECIALLY PROTECTED RECORDS

I understand that if my health record contains information in reference to drug / alcohol abuse, psychiatric/ mental health care, HIV / AIDS, mental retardation, or genetics testing, I agree to its release.

☐ I agree ☐ I do not agree, please specify

TIME LIMIT, RIGHT TO REVOKE, RE-DISCLOSURE AND TREAT

The El Paso Children's Hospital is hereby released from legal responsibility or liability for the disclosure of the records to the extent indicated and authorized herein. I also understand that I may revoke this authorization in writing at any time (except that action has been taken in reliance on this authorization) by sending a written notice to the Privacy Officer, El Paso Children's Hospital, 4845 Alameda Ave, El Paso, Texas, 79905.

Unless otherwise revoked, this authorization will expire 180 days from the date of my signature or as otherwise specified by an event related to the patient or the purpose of the disclosure as follows: _____

_____

I understand that El Paso Children's Hospital may not deny treatment based on my completion of this authorization form.
Fees/charges will comply with all laws / regulations applicable to release of information as stated.
I understand that this health information may no longer be protected by federal and state privacy laws once it is disclosed, and, therefore, may be subject to re-disclosure by the recipient.

DATE: _____ SIGNATURE: _____

TIME: _____

_____ _____

Relationship to patient Printed name of the patient or legally authorized representative

IDENTITY VERIFICATION

Identity of requestor verified via: ☐ Photo ID ☐ Matching Signature ☐ Other (Specify) _____

El Paso Children's HOSPITAL

Authorization for the Use & Disclosure of Protected Health Information

PATIENT INDENTIFICATION LABEL