Authorization for Release of Medical Information

Health Information Management
Mon – Fri 8:30am to 5:00pm
111 Michigan Avenue, NW
Washington, DC 20010
Phone (202) 476-5267
Fax (202) 476-2270
medicalrecords@childrensnational.org

Select Location(s) for Request:

- ❑ Children's National Hospital
- ❑ Children's National Pediatrics & Associates
- ❑ Rehabilitation and Specialized Care
- ❑ Dentistry*** □ Radiology***

Medical Record # *(Office Use Only)*

Patient Name | Date of Birth | Phone Number

Street Address | City, State, Zip Code

(1) I, the undersigned, hereby authorize Children's National Medical Center to use and/or disclose the above-named individual's health information to:

Name of Person and/or Agency | Phone Number

Street Address | City, State, Zip Code

(2) Provide the records by means of:

□ Secure E-mail _____ □ Fax (Immediate Patient Care Only) _____
□ Mail □ CD

(3) Date of Service (specify date range):_____ to_____and for the purpose of:

□ Continued Medical Care □ Self □ School □ Other: _____

(4) Release the following information (check all applicable information to be released):

□ Abstract/ Summary □ Inpatient Record □ Outpatient Report □ All Records
□ Immunization Record □ Laboratory Report □ Behavioral Health Record
□ Well Child Record □ Radiology Report □ Child and Adolescent Protective Center
□ Physicals/School Form □ Emergency Room Record □ Home Care Therapy Record
□ Other _____

*****For Radiology films/images, please call (202) 476-3426 ***For Dental Records, please call (202) 476-2160**

(5) I understand the above- named individual's health information may include information relating to sexually transmitted diseases, genetics, sexual activity including contraceptive methods, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) where applicable. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse in accordance to 42 CFR Part 2.

(6) I understand that I have the right to revoke this authorization at any time. If I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to process a claim under my policy. **This authorization will expire within six months** unless otherwise revoked for the following date, event, or condition: _____.

(7) I understand that authorizing the disclosure of this health information is voluntary. I understand that there are fees associated with re-disclosures excluding for direct patient care (i.e., practitioner to practitioner communication). I understand that I may inspect the information to be used or disclosed as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosures, and the information may not be protected by federal confidentiality rules.

(8) **PSYCHIATRIC TREATMENT: This authorization does not apply to any mental health information obtained after the signed date of the authorization below. The unauthorized disclosure of mental health information violates the provisions of the District of Columbia Mental Health Information Act of 1978. Disclosure may be made pursuant to a valid authorization by the client or as provided in Title III or IV of the Act. The Act provides for civil damages and criminal penalties for violation.

(9) I do hereby declare that I am the patient/parent/legal guardian and am responsible for the release of information with regard to the above- named patient. (Appropriate documentation will need to be provided with authorization in order to process release). **NOTE: If a patient is of legal age (18), patient will need to sign the release themselves.**

_____
Signature of Patient

_____ _____
Print Name of Parent or Legal Guardian Date

_____ _____
Signature of Parent or Legal Guardian Witness

MEDREC7

REV05/2003, 06/2014, 10/2017,8/2018, 11/2019, 7/2020, 9/2020,2/2022,9/2022,11/2023,12/2024