Complex Chronic Care Medical Services

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME:	DATE:
DOB:	MEDICAL RECORD NUMBER:

I, _____ , certify that I am the patient or legal representative of the patient, and I hereby authorize **Complex Care Medical Services** to disclose the following Protected Health Information:

- ☐ Immunization Records
- ☐ Lab Results
- ☐ Medical Records:
  - ☐ Only information related to (Specify): _____
  - ☐ Only the visit notes dated from: _____ to _____
  - ☐ Entire medical record
- ☐ Other _____

I understand that the purpose(s) of the requested disclosure is (are):

- ☐ At the request of the Patient or Legal Representative
- ☐ Other _____

This information may be disclosed to:

Name of person or organization _____

Address _____

City/State/Zip _____

Phone number _____ Fax number _____

I understand that the records released may include information relating to Human Immunodeficiency Virus (HIV) infection or acquired Immunodeficiency Syndrome (AIDS) and/or treatment for or history of drug or alcohol abuse, mental, behavioral or psychiatric care.

I understand that Complex Care Medical Services may not condition treatment on my completion of this authorization form. I also 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.

This request will expire in 180 days unless otherwise revoked. I may revoke this authorization in writing at any time (except to the extent that action has been taken in reliance on this authorization) by sending a written notice to the Privacy Officer, Children's Medical Center, 1935 Medical District Drive, Dallas, Texas 75235, or by faxing a written notice to the Privacy Officer at 214-456-5299.

_____ _____

Signature of Parent or Legal Guardian | Printed Name of Parent or Legal Guardian

_____ _____

Relationship to Patient | Date