The Children's Heart Clinic

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Information	Print Legal Name: _____ DOB: _____ Street Address: _____ City: _____ State: _____ Zip: _____ Parent/Guardian_____
Health Information released FROM:	☐ Children's Heart Clinic ☐Other Person/Organization: _____ Address: _____ _____ Phone: _____ FAX: _____
Health Information Released TO:	☐ Children's Heart Clinic ☐Other Person/Organization: _____ Address: _____ _____ Phone: _____ FAX: _____
Information Requested:	Dates : From_____ To: _____ ☐Clinic Visit Notes ☐Echocardiogram ☐EKG ☐Hospital Reports ☐Other All records will be released including genetic diseases and HIV/AIDS unless checked here____ Please DO NOT RELEASE INFORMATION REGARDING:_____
Purpose for Release:	☐Insurance ☐Continuation of Care ☐Personal ☐Transfer to Pediatric Cardiology ☐Moved ☐Transfer to Adult Cardiology ☐Legal
Authorization/ Revocation:	This authorization will last one year after the date of signature. This authorization may be cancelled in writing at any time to the Children's Heart Clinic. A cancellation will not change releases that happen before the cancellation. The Children's Heart Clinic will not restrict any treatment if I choose not to sign the authorization. The Children's Heart Clinic cannot prevent re-disclosure of your information by the person or organization and may not be covered by state and federal privacy laws. I understand my signature indicates that I have read and understand this form, and authorize release of my health information as described above. X_____ X_____ Signature Date (If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.) _____ Relationship to patient(if not patient) **Note:** An adult patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. Legal documentation of the right of access by the signing individual may be required.