920010

Children's
HOSPITAL & MEDICAL CENTER

8200 Dodge Street
Omaha, NE 68114
Phone (402) 955-3800; Fax (402) 955-7193

Patient Label

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I hereby authorize Children's Hospital & Medical Center to release the following information:

Patient Name _____ Date of Birth _____

Address _____ Telephone _____

City _____ State _____ Zip Code _____

Dates of Service: From (date) _____ To (date) _____

Information to be released:

Hospital Records
- ☐ Primary Documents- Physician Reports/Diagnostic Tests

OR
- ☐ Emergency/Urgent Care Report
- ☐ Discharge Summary
- ☐ Radiology Report
- ☐ Lab Tests
- ☐ Patient Condition (for release to media)
- ☐ Other_____

Specialty Pediatric Center Records
- ☐ Primary Documents- Physician Reports/Diagnostic Tests

OR
- ☐ Lab Tests
- ☐ Radiology Reports
- ☐ Other _____
- ☐ Specific Physician/Clinic: _____

Children's Physician Records
- ☐ Primary Documents- Physician Reports/Diagnostic Tests

OR
- ☐ Lab Tests
- ☐ Radiology Reports
- ☐ Other _____
- ☐ Specific Physician/Clinic: _____

Children's Home Health Records
- ☐ Primary Documents- Physician Reports/Diagnostic Tests

OR
- ☐ Lab Tests
- ☐ Radiology Reports
- ☐ Other _____

This information is to be disclosed to (Name & Address):

_____

_____

_____

Method of Delivery:
- ☐ Record will be picked up (will call when ready)
- ☐ Record to be sent via 1st class mail* to address at left via (please check one):
  - ☐ Paper Format
  - ☐ CD Format (Unencrypted)
  - ☐ CD Format (Encrypted-will require WinZip)

*Children's Hospital and Medical Center is not responsible for copies of records once they have been mailed.

Purpose of information to be disclosed:_____

To the extent allowed under HIPAA, I also authorize release of information relating to (initial if applicable):
_____ Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection
_____ Behavioral Health Services/Psychiatric Care
_____ Eating Disorder Clinic Records

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. I further understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient. Unless otherwise revoked, this authorization will expire on the earlier of the identified date below or 12 months from date of signature.

This facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. Please note that it is the practice of Children's Hospital & Medical Center to only release information created by this facility and not re-disclose information created elsewhere.

Signed _____ Date _____
(Patient or Legal Representative) *(Relationship to Patient)*

Printed Name: _____

Date of Expiration: _____

Please Complete this Box Before Sending to HIM

____Records need to be released by HIM

____Records have been released (check one below)
____ Verbal ____Faxed ____ Mailed ____ In-person

Name:_____ Date:_____