Casper Children's Center

AUTHORIZATION TO RELEASE/DISCLOSE MEDICAL RECORDS
HIPAA COMPLIANT RELEASE OF PATIENT INFORMATION
PURSUANT TO 45 CFR 164.508

FROM: _____

_____

_____

RE: Patient Name: _____

Date of Birth: _____

I authorize and request my healthcare provider as specified above to disclose my protected health information to Casper Children's Center for the purpose of continuing medical care.

I am authorizing release of all medical records pertaining to pediatric diagnostic assessment and care of the above patient, and to disclose full and complete protected medical information to CCC and its representatives.

☐ All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes; inpatient, outpatient, and emergency room treatment; all clinical charts, reports, order sheets, progress notes, nurses' notes, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations; medication administration reports; documents, test results, statements, questionnaires/histories; and records received by other medical providers.

☐ All physical, occupational, and other therapies' requests and related consultations.

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☐ All laboratory, histology, cytology, pathology, immunohistochemistry records, and specimens reports; radiology records and images.

I understand the medical records to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), alcohol and drug abuse, and/or mental health/psychiatric conditions and/or treatments. I have the option to refuse to release this type of medical information. I understand that if I check the "Yes" box below and add my initials, I am authorizing the release or disclosure of this type of information.

☐ Yes _____ (Initials) ☐ No

I understand the following: See CFR §164.508(c)(2)(i-iii)

a. The healthcare provider(s) who will receive this authorization are specified above.
b. By signing this authorization form, I am permitting the release of medical records to CCC.
c. I have a right to revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing and present my written revocation to CCC and the health care providers who previously received my authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization.
d. My treatment or payment for my treatment will not be impacted by the signing of this authorization.
e. I will receive a copy of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize the release the records requested herein to CCC and its representatives.

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Printed Name of Patient

Signature of Patient or Parent/Legal Guardian (See 45CFR § 164.508(c)(1)(vi))

Date

Name and Relationship of Parent/Legal Guardian (See 45CFR §164.508(c)(1)(iv))