SHRINERS HOSPITALS FOR CHILDREN

Authorization for Disclosure of Health Information

Patient Name: ____________________ Medical Record # __________ Date of Birth ____________

Address: ____

______________________________ Telephone ______________

for the period(s) of health care

From (date) ____________________ to (date) ____________________
From (date) ____________________ to (date) ____________________

1. I hereby authorize Shriners Hospitals for Children, ____________________ to disclose to:

   Name ______________________________

   ____

   Street Address: ______________________________
   City, State & Zip Code: ______________________________

2. Information to be disclosed:

☐ Discharge summary	☐ Progress notes	☐ Operative reports
☐ History & physical examination	☐ Laboratory tests	☐ Consultation reports
☐ X-ray reports	☐ Photographs/slides	☐ Other __________

3. Reason for disclosure: ______________________________

4. Separate signature required for release of information related to items below. Initial each line if required.
   ___ Acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV)
   ___ Behavioral health services/psychiatric care
   ___ Treatment for alcohol and/or drug abuse
   ___ Pregnancy, contraceptives, and sexually transmitted diseases
   ___ Genetics testing

   Signature for release of information in Item 4: ______________________________

5. 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. **Unless otherwise revoked, this authorization will expire one year (12 months) from the original date for release of information to family members; six (6) months from the original date for all other releases.**

6. I hereby release and agree to indemnify and hold harmless Shriners Hospitals for Children, it successors and assigns, and its agents and employees, from and against any claim or cause of action based on the release of requested health records and/or health information I previously authorized.

7. The recipient of this information might disclose it to other people. Shriners Hospitals for Children has no way to prevent this re-disclosure and cannot be held liable for such re-disclosures.

8. I understand that I do not have to sign this authorization. My failure or refusal to sign will not affect my child's or my treatment at Shriners Hospitals for Children.

Witnessed by: ______________________________

____
Signature of Father or Legal Guardian

____
Signature of Mother or Legal Guardian

Date: ______________________________

____
Signature of Patient (if 14 years of age or older)