CHILDREN & TEENS MEDICAL CENTER
Request for Release of PHI from a Hospital or other Medical Provider

Name of Patient: ____ **Date of Birth:** _____________
Address: ____
____

We are requesting a release of information from:

Name of Doctor/Hospital: ____
Address: ____
____

Fax #: __________________________ **Phone #:** __________________

Date of Service: **From:** _______________ **To:** ______________________

Please release the following:

Consult notes ______
Lab/PKU report ______
XRAY reports ______
NB/DC Papers ______
ER report ______
Immunization dates ______
Weight ______
Growth chart ______
Other ____

Please release for the following purpose(s):

Continuing medical care: ____________________________ **Legal:** _____________

Other: WE ARE PATIENTS PRIMARY CARE PHYSCIAN____________________________________

Please release information to:

Name of Doctor/facility: ____

Address: ____

Kindly fax to: ____

First/Last name and title of requesting employee: __________________________

Message: ____

I hereby authorize the release of my specified protected health information from the above stated facility and/or Physician to be released to Children and Teens Medical Center effective as of today's date and expiring within 6 months of the date of this request. I understand that I may revoke my authorization at any time in writing except to the extent that action has already been taken. Information released outside of Children & Teens Medical Center may be re-disclosed and no longer protected by HIPAA privacy laws.

Signature: _______________________________ **Print Name:** _______________________

Relationship to patient: _____________________ **Date:** ____________________________

Expiration date (6 months from date of request unless otherwise specified)