111 Michigan Avenue, NW
Washington, DC 20010

# Authorization for Release of Medical Information

Patient Name: ______________________________________ Medical Record No.: ______________
Date of Birth: ______________________________________

1. I, ________________________________________, authorize the use or disclosure of the above named individual's health information as described below.

2. Children's National Medical Center is authorized to make the disclosure to:
______________________________________________________________
Address______________________________________________________
For the purpose of: ☐ Continued Medical Care ☐ School ☐ Self ☐ Other:__________________

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)
☐ Problem List
☐ Medication List
☐ Immunization Record
☐ Ambulatory Treatment Record *(commonly used during clinic visits, specify dates)*
________________________________________
☐ Abstract (Discharge Summary, History and Physical, Consultation, OR Report, Radiology, Pathology, Lab Reports and Progress Notes) ______________________________
☐ History and Physical *(specify dates:)* ______________________________
☐ Discharge Summary *(specify dates:)* ______________________________
☐ Outpatient Report *(specify dates:)* ______________________________
☐ Laboratory Results *(specify dates:)* ______________________________
☐ Radiology Reports inc. imaging reports ______________________________
☐ Consultation Reports *(specify dates:)* ______________________________
☐ Entire Record *(specify dates:)* ______________________________
☐ Psychiatric Treatment ***(see below)*** ______________________________
☐ Other: ______________________________

4. I understand that the above named individual's health information may include information relating to sexually transmitted disease, genetics, sexual activity including contraceptive methods, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency Virus (HIV) where applicable. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department of the Medical Center. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to process a claim under my policy. Unless otherwise revoke, this authorization will expire on the following date, event, or condition: ______________________
If I fail to specify an expiration date, event or condition, this authorization **will expire within six months.**

6. I do hereby declare that I am the legal guardian and am responsible for the release of information with regard to the above patient. I understand that authorizing the disclosure of this health information is voluntary. I also understand that there are fees associated with redisclosures excluding copies needed for direct patient care involving practioner to practioner communication. I understand that I may inspect the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

7. PSYCHIATRIC TREATMENT: The patient or legal guardian must sign below for release of Psychiatric Treatment records. I understand that I am entitled to inspect the above named patient's record and am entitled to revoke my consent except in certain insurance cases. This authorization does not apply to any Mental Health information obtained after the date of authorization above. The unauthorized disclosure of mental health information violates the provisions of the District of Columbia Mental Health Information Act of 1978. Disclosure may be made pursuant to a valid authorization by the client or as provided in Title III or IV of the Act. The Act provides for civil damages and criminal penalties for violation.

______________________ ______________ ______________
(Parent or Legal Guardian) (Date) (Phone)