



PATIENT GUIDE TO RELEASE OF MEDICAL RECORDS

How to Get Authorization

To request a copy or have a copy of the medical record sent to another party, call Cook Children's Release of Information Department in the main hospital building at 682-885-1012 between the hours of 8:00 am and 5:00pm Monday through Friday. We will be happy to mail, fax, or email you a form. We also have the authorization available for downloading from our web site www.cookchildrens.org . From the Patient and Families tab select Request Medical Records and follow prompts.

Who Must Authorize Release of Information

Parents or legal guardians (without court imposed restrictions) may obtain and/or authorize the release of protected health information from their child's Cook Children's medical record. Individuals over the age of 18 must authorize the release of their own information. If used patient representative must be specially indicated.

Written Authorization: What to Do

1. Carefully read the authorization form.
2. Provide all requested information.
3. Be very specific about the information you need released. Write down dates, types of visits, and what parts of the record you need. (if you do not know specific dates of service a date range can be used: for example month & year or just year)
4. For x-ray films/images, please state on the form that you need x-ray films/images.
5. Sign and date the authorization using your full legal signature.
6. Please remember, we will return the form to you if any information is missing or incomplete. This may delay the release of information.
7. **Mail authorization form to Attention: HIM Medical Record Release, Cook Children's, 801 Seventh Ave, Fort Worth TX 76104 or fax to 682-885-1909 or email to releaseofinformation@cookchildrens.org . For questions please contact a Record Release Representative at 682-885-1012.**

Before Releasing a Record

You must provide a valid government issued picture identification card when picking up records from our office or signature verification may be made.

Time for Release

Because of the number of requests we receive, it may take up to 15 days to process a request. If you plan on picking up the records, please call ahead of time to ensure they are ready when you arrive. If you have any questions related to the time frame please contact a record release representative at 682-885-1012.

This form, if signed, will authorize Cook Children's Health Care System (CCHCS) to use and release certain health information about the person named below. All items must be completed and the authorization signed and dated by an authorized person to be valid. I understand this authorization is voluntary, I may refuse to sign this authorization and I understand that CCHCS may not withhold treatment because I refuse to sign this authorization.

1. I authorize CCHCS (check (√) one or more): MedicalCenter Physician Name/Clinic Name: _____
 Home Health to release health information, as described below, from the
 medical record of:
 Patient's Full Name: _____ Date of Birth: _____

2. The information specified below may be released to:
 Name/Company: _____
 Address: _____ Telephone: _____
 City: _____ State: _____ Zip: _____

3. The specific purpose(s) for this disclosure is/are [check (√) your selection(s)]: my personal records; share with other
 healthcare providers as needed; social security / disability; military; education; other (please describe)

4. Must select one: I want OR I do not want the specified information to be released to include history, diagnosis and/or
 treatment for: HIV/AIDS/testing, Communicable diseases, Drugs/Alcohol, Mental Health disease.

5. SPECIFY EXACT INFORMATION TO BE RELEASED: (1) Place a check (√) next to the specific medical information to be released,
 (2) list the specific dates of treatment, and (3) list the physician or clinic name if physician office records are requested:

√	INFORMATION	DATES OF SERVICE	√	INFORMATION	DATES OF SERVICE
	Hospitalization Reports (most pertinent information)			Immunization Information/ Other Test Results	
	Discharge Summary			Psychological Evaluation	
	History & Physical			Operative Report	
	Emergency/Urgent Care			Consultation	
	Lab			Specialty Clinic Notes:	
	X-ray report			Audio, PT, OT, Speech Evaluation(s)	
	X-ray images			Other:	

Approve verbal communication with: _____ for visit date: _____ Initial: _____

6. I understand and acknowledge the following statements: I may be asked to show proof that I have the authority to sign an authorization to review, receive or release to another party copies of the above named patient's medical record which I am requesting. In order to inspect or receive a copy of the medical record of for myself, I must complete and sign this authorization form. If I request to do so, I may inspect medical information to be released to another party after signing this form. Unless required or allowed by law, the medical information will not be released to another party, if, after inspecting the medical information, I revoke this authorization prior to the release of the medical information. After the above medical information is released, it may be re-released by the recipient and the information may no longer be protected by federal privacy laws or regulations. A facsimile or photocopy of this authorization is as valid as the original. I will be charged a fee for any copies of my medical records or my child's medical record I request for myself or for use by others. Fees for copies are due and payable before copies are released. I may revoke this authorization at any time by notifying CCHCS in writing to ATTN: Cook Children's Health Care System, Medical Record Department, of my intent to revoke this authorization, except that if I do notify CCHCS in writing of my intent to revoke this authorization, such revocation will not have any affect on any actions by CCHCS taken before the revocation. Unless otherwise revoked in writing, this authorization will EXPIRE 180 DAYS from the date this form is signed.

7. _____
 DATE Signature of Patient, Parent or Legally Authorized Representative Relationship to Patient

8. _____
 Printed Name of Parent or Legally Authorized Representative Patient ID Number (Office use only)

(NOTE: All items in this authorization must be completed to be valid and executable)



CORRESP



801 Seventh Avenue
 Fort Worth, Texas 76104-2796

AUTHORIZATION FOR USE & DISCLOSURE
 OF PROTECTED HEALTH INFORMATION

PRINT OR IMPRINT PATIENT INFORMATION