CHILDREN'S HEALTHCARE OF ATLANTA
SIBLEY HEART CENTER CARDIOLOGY
AUTHORIZATION TO RELEASE/OBTAIN PROTECTED HEALTH INFORMATION

PATIENT INFORMATION: Please insert the full legal name specific to the patient for whom information is being requested.

SENDING ORGANIZATION: Identify which Children's Healthcare of Atlanta Hospital or Clinic you are seeking information. Please be specific in your request. If you do not specify a hospital or clinic, records may be provided from ALL Children's Healthcare of Atlanta hospitals and clinic locations.

If authorizing Children's Healthcare of Atlanta to obtain information from another facility on your behalf, please include the full name of the person/business, phone number, fax number and as much additional contact information as possible.

RECEIVING PERSON/ORGANIZATION: Identify the full name of the person/business, address, and phone of the entity receiving the information.

INFORMATION TO BE RELEASED: This section gives us the instructions on what information is to be released. If you select "Routine Record Set", we will disclose the documents that are specific to the patient care visit. This is typically what doctors' offices, hospitals or other healthcare providers need to provide information related to your care. If you select "Any and All Records", your entire record will be provided for a specific visit date or all dates. It is very helpful if you identify the date or range of dates needed by the requester.

RELEASE INSTRUCTIONS: This tells us how you would like your information delivered. We can print the documents, create a CD or, you may set up an appointment for viewing. If you wish to view information prior to selection of documents, please identify this on the authorization form and we will contact you to set up a viewing appointment. It is Children's Healthcare of Atlanta's policy NOT to fax or email patient information except for direct patient care requirements (e.g. to a doctor or clinic). *Please note*: If you select "verbal" release, you are permitting Children's Healthcare of Atlanta to discuss and disclose confidential Protected Health Information (PHI) with the named recipient. Only clinical staff is permitted to verbally release PHI.

PURPOSE OF THE REQUEST: Please identify the reason why a copy of the patient record is needed. This helps us to track and assign a priority status to your request. It also informs us who may be responsible for the cost of records (where appropriate).

DURATION OF CONSENT, REVOCATION AND OTHER INFORMATION YOU NEED TO KNOW: This consent will automatically expire in 12 months UNLESS you write some other date or event. The authorization is revoked at your written direction to our organization.

Submit Medical Record Request to:

Sibley Heart Center Cardiology
Health Information Services
2835 Brandywine Rd.
Suite 400
Atlanta, GA 30341
Phone: 404-256-2593
Fax: 770-488-9403
HIS@kidsheart.com

For a list of Sibley Heart Center locations and addresses please visit www.choa.org/cardiology.

22035-01

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SIBLEY HEART CENTER CARDIOLOGY
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PATIENT INFORMATION	Name: (First, Middle, Last) Date of Birth:
SENDING ORGANIZATION (Name of the person or facility that will be releasing your information)	___Children's Healthcare of Atlanta (LOCATION): _____ - OR- ___ Other Facility (non-CHOA): Name of person or Facility: _____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____
RECEIVING PERSON/ ORGANIZATION (Name of the person or facility that will be receiving your information)	___Children's Healthcare of Atlanta - OR- ___Other Facility or Person (non-CHOA) Name of Person or Facility: _____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____
INFORMATION TO BE RELEASED	Indicate Applicable Dates of Service: _____ ***Check the Types of Information to be Released:*** ___Any and All Records ___ Routine Record Set ___Clinic record ___ Lab Reports ___ Billing Records ___Other: _____
RELEASE INSTRUCTIONS	**Please Choose Release Method/Format**: **Delivery Method:** ___ Email: _____ ___Mail (to address listed above) ___Verbal (Recipient Name: _____) ___Pick-up____Fax (Patient Care Only) ___CD ___ Flash Drive _____Paper Fax #: _____
PURPOSE OF RELEASE	___Continuing Care____Insurance Reimbursement____Legal Action/Review____Personal Use ___Social Security Disability Determination ___Other: _____

I acknowledge and agree that I have read (or had someone read to me) the following statements:

- This Authorization **expires in 12 months** from the signed date unless an alternative date is inserted here: _____.
- I place no limitations on history or illness (including HIV and/or AIDS, genetic, drug dependency or psychiatric information) or diagnosed and therapeutic information, including any treatment for alcohol, drug abuse, or psychiatric disorders.
- I may refuse to sign this authorization and that it is strictly voluntary and that my treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- I may revoke my consent at any time by submitting my revocation request in writing. The revocation of this request will not affect any health information disclosed prior to Children's Healthcare of Atlanta receiving my written notice.
- I understand that information disclosed may be subject to redisclosure and may no longer be protected by federal privacy regulations.
- I understand that if I have consented to verbal release, confidential information disclosed may include information about the patient's treatment at Children's obtained from interviews of the family, physicians and hospital personnel, or from the patient's medical records, including images of any kind, and I place no limitation on the PHI disclosed pursuant to this authorization. I hereby waive the right to or interest in the confidentiality of this patient information.
- I understand that I have a right to see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask.
- I understand that I may have a copy of this signed form, if I ask for one.

ATTENTION: Please review the information below carefully. If information is missing, the request may not be processed.

- **If the patient is 18 years of age or older**, the patient must sign and date the form.
- **If the patient is 18 years of age or older and lacks capacity to sign**, a legally authorized person may sign and date the form. Please indicate your legal authority and include documentation of your relationship:
  ___Legal Guardian or Conservator ___Health Care agent (Health Care Power of Attorney)
- **If the patient is 17 years of age of younger**, the patient's parents or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship:
  ___Parent ___Legal Guardian

By signing, I understand that I am authorizing Children's Healthcare of Atlanta to release/obtain information as described above. I hereby release Children's (and its affiliates, officers, directors, trustees, employees, medical staff members and agents) from any and all claims, liability, suits or costs related to the use of images or disclosure of the information and materials described herein.

Patient/Legal Guardian Signature Date Authority to act on behalf of patient (attach document)