

**Authorization for Disclosure of Copies of Protected Health Information to Third Parties**

*This form authorizes Texas Children's Hospital to disclose copies of a patient's protected health information to third parties. A patient wishing to view his/her own information must complete a patient request for access form. Please see the instruction page (attached) before completing this form.*

**I.** Patient name: \_\_\_\_\_ Birth date: \_\_\_\_\_

Mailing address: \_\_\_\_\_ Home phone: \_\_\_\_\_

City, State, ZIP: \_\_\_\_\_ Dates of service: \_\_\_\_\_

**II.** Check the reports to be disclosed (fee schedule available in HIM Department):

Abstract - includes face sheet, discharge summary, history and physical exam, operative and pathology reports, consultation reports, radiology reports and EEGs

Or:

Discharge summary

Operative reports

History and physical exam

Clinic/outpatient record

Consultation reports

Which clinic or doctor? \_\_\_\_\_

Progress notes

Billing claim forms

Radiology reports

Itemized statement of charges

Laboratory reports

Other, specify: \_\_\_\_\_

Pathology reports

All information

Or, for mental health records (may require physician/psychologist approval):

Psychiatric/mental health records

LSC/CAP records

Neuropsychological testing

Other, specify: \_\_\_\_\_

All information

Please note that currently Texas Children's Hospital can provide only paper copies for most reports.

**III.** Mail copies to: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

**IV.** The information described above may be disclosed for the purpose of: \_\_\_\_\_

**V.** I authorize Texas Children's Hospital ("Texas Children's") to disclose the information described above. I understand:

- This authorization expires 180 days from the date of my signature unless I specify otherwise. Expiration: \_\_\_\_\_
- I may revoke this authorization at any time by notifying Texas Children's in writing. If I revoke the authorization I understand that it will have no affect on actions Texas Children's took in good faith before receiving the revocation.
- If the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
- The information released may contain information related to AIDS or HIV infection; drug or alcohol abuse; mental or behavioral health or psychiatric care, except for psychotherapy notes.
- Texas Children's reserves the right to verify my identity/guardianship.
- I will be charged for the copies requested.
- I understand that Texas Children's may not condition treatment or payment on my completion of this form.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**Mail or deliver completed form to:**

Release of Information, MC-A1195

Texas Children's Hospital

6621 Fannin Street

Houston, TX 77030

For more information, contact Texas Children's Health Information Management Department  
at 832/824-1634, -1651, or -1670 (Fax: 832/825-9056 or -0110)