0 2 2 8

THE UNDERSIGNED HEREBY AUTHORIZES NICKLAUS CHILDREN'S HEALTH SYSTEM TO RELEASE/REQUEST INFORMATION CONTAINED IN THE PATIENT RECORD WHICH MAY INCLUDE PATIENT AND/OR PARENTAL PSYCHIATRIC OR DRUG ABUSE INFORMATION, HIV TESTING, DIAGNOSIS AND TREATMENT INFORMATION AND/OR AIDS RELATED INFORMATION.

PATIENT INFORMATION:

Patient's Name (please print): _____ Date of Birth: _____

Name of Patient/Parent/Legal Guardian completing this form: _____

Patient/Parent/Legal Guardian Address: _____

RELEASE TO:

Name: _____ Institution (if applicable): _____

Address: _____ Phone: _____ Fax: _____

_____ Email Address: _____

INFORMATION TO RELEASE (select one):

☐ Paper ☐ CD ☐ Electronic/Email (Electronic Authorization Form Required)

Dates of Hospitalization or Treatment Requested: From Date: _____ To Date: _____

☐ Face Sheet	☐ History & Physical	☐ PT/OT/ST	☐ Immunizations
☐ Discharge Summary	☐ Consultations	☐ Operative Report	☐ Lab
☐ Pathology	☐ Radiology	☐ Medications	☐ Physician Orders
☐ Progress Notes	☐ Echo	☐ EKG	☐ EEG
☐ Pulmonary Function Test	☐ Sleep Study	☐ D/C Instructions	☐ If Other (Specify Below)
☐ *Drug Substance (initial) _____	☐ *Behavioral/Psychiatry (initial) _____	☐ *Lab-Sensitive/Genetics (HIV/STD/Drug Screen/Pregnancy) (signature required) X _____	
☐ **COMPLETE MEDICAL RECORD** ☐ Include psychology/psychiatry records ☐ Exclude psychology/psychiatry records			

Other (PLEASE SPECIFY):_____

PURPOSE:

☐ Healthcare ☐ Third Party Payor ☐ Personal ☐ Attorney/Legal ☐ OTHER (PLEASE SPECIFY)_____

I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING TO THE MEDICAL RECORDS DEPARTMENT BEFORE THE EXPIRATION DATE, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE ON THIS AUTHORIZATION. UNLESS OTHERWISE REVOKED, THIS AUTHORIZATION WILL EXPIRE IN ONE (1) YEAR FROM THE DATE SIGNED OR ON THE FOLLOWING DATE _____. I ALSO UNDERSTAND THAT IN THE EVENT I DO REVOKE THIS AUTHORIZATION, IT WILL NOT HAVE ANY EFFECT ON ACTIONS TAKEN BY NICKLAUS CHILDREN'S HOSPITAL PRIOR TO RECEIPT OF THE REVOCATION. I UNDERSTAND THAT IF THE PERSON OR ENTITY THAT RECEIVES THE INFORMATION IS NOT A HEALTH CARE PROVIDER OR HEALTH PLAN COVERED BY FEDERAL PRIVACY REGULATIONS, THE INFORMATION DESCRIBED ABOVE MAY BE REDISCLOSED AND NO LONGER PROTECTED BY THESE REGULATIONS.

PATIENT'S SIGNATURE (if 18 years of age or older OR is an emancipated minor)	PHONE	DATE
PARENT, GUARDIAN, OR OTHER LEGAL REPRESENTATIVE X	RELATIONSHIP TO PATIENT	DATE

AUTHORIZATION MUST BE SIGNED AND DATED BY THE PATIENT, PARENT OR LEGAL GUARDIAN/REPRESENTATIVE. A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL. Note: If this authorization is signed by the Legal Guardian, Court Appointed Special Advocates, or Guardian ad Litem, documentation establishing relationship may be requested, to comply with this request. On the patient's 18th birthday, the parent or guardian's access to the patient's health record is terminated.

Nicklaus Children's Health System

NICKLAUS CHILDREN'S HOSPITAL
3100 SW 62 AVENUE
MIAMI, FL 33155
FORM # 798.076.0228 (NURS0228)
VERSION 5 REV 11/2021

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION