The Children's Hospital of Philadelphia

MR-109
AEL 9/2005

NAME SEX M F

MR#

AGE / DATE OF BIRTH

ACCOUNT#

(PATIENT PLATE OR PRINT)

AUTHORIZATION TO RELEASE/OBTAIN PATIENT INFORMATION

This authorizes The Children's Hospital of Philadelphia and its affiliates to release/obtain information as described below. For a listing of related entities and medical practices, see The Children's Hospital of Philadelphia *Notice of Privacy Practices.*

1. **Patient Name (First, Middle, Last):** _____
   Address of Patient: _____
   City, State, Zip: _____
   Telephone Number: _____ **Date of Birth:** _____

2. **What is the name of the person or facility that will be releasing your information?** Check the appropriate box below and provide the name, address and telephone number of the person/facility releasing the information.
   ☒ **The Children's Hospital of Philadelphia** or ☐ **Other**
   Name of Person / Facility: _____
   Address: _____
   City, State, Zip: _____
   Telephone Number: _____ Fax Number: _____

3. **What information will be released?** Date of appointment or hospital stay beginning _____ through to _____
   ____ **Emergency Department** ____ **Home Care** X **Outpatient** Any & All Audiological
   ____ **Inpatient** ____ **Immunization** *(please specify name of department/office)*
   ____ **Other Information** *(please specify)* and Hearing Aid Reports
   If there is any part of the record you do not wish released, please indicate here: _____
   If your records contain any information about substance (drug or alcohol) abuse, HIV, or mental health, may this information be released? If yes, please initial next to each type of information to be released:
   Drug and/or alcohol treatment or testing _____ **HIV** _____ **Mental Health** _____

4. **What is the name of the person or facility who is to receive your information?** Check the appropriate box below and provide the name, address and telephone number of the person/facility receiving the information.
   ☐ **The Children's Hospital of Philadelphia** or ☒ **Other**
   Name of Person / Facility: Clarke Schools for Hearing and Speech
   Address: 455 S Roberts Road
   City, State, Zip: Bryn Mawr, PA 19010
   Telephone Number: 610-525-9600 Fax Number: 610-525-9655

5. **Please explain why the person or facility above needs this information:**
   _____

6. **Expiration.** Your permission will expire 90 days after you sign this form unless you indicate otherwise. If you would like to extend your permission for longer than 90 days, please tell us when your permission expires. The date cannot be more than a year from now: _____.

7. **Understanding this Authorization**
   - This allows the release or obtaining of information that exists in the patient's medical record when the form is signed, as well as information created after the form is signed until it expires.
   - I may withdraw my permission at any time by providing written notice to the above-named provider releasing the information. For information being released by The Children's Hospital of Philadelphia, see its *Notice of Privacy Practices* for instructions on how to withdraw (revoke) an authorization. If I withdraw my permission, any information that was already released cannot be retrieved.
   - Information released by The Children's Hospital of Philadelphia may be released again by the person or organization that receives it and is no longer protected under federal privacy laws. The Children's Hospital of Philadelphia will protect information it obtains as required by federal privacy laws.
   - I understand my permission is voluntary and I/my child will receive treatment whether or not I sign this form.

8. **Signature.** By signing, I understand that I am authorizing The Children's Hospital of Philadelphia to release/obtain information as described above.

_____ _____ _____
Signature Print Name Date

Relationship to patient: ☐ Patient ☐ Parent ☐ Legal Guardian ☐ Other: _____

Information Released by: _____ Date: _____

WHITE – MEDICAL RECORDS YELLOW – PATIENT/PARENT/LEGAL GUARDIAN

AEL 10/2005