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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'S NAME (PLEASE PRINT) DATE OF BIRTH

NAME AND ADDRESS OF INDIVIDUAL OR INSTITUTION TO WHOM DISCLOSURE IS TO BE MADE:

PLEASE SELECT THE TYPE OF INFORMATION TO BE DISCLOSED: SELECT  PAPER  CD  ELECTRONIC (Electronic Authorization Form Required)

<input type="checkbox"/> Face Sheet	<input type="checkbox"/> History & Physical	<input type="checkbox"/> PT/OT/ST	<input type="checkbox"/> Immunizations
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Consultations	<input type="checkbox"/> Operative Report	<input type="checkbox"/> Lab
<input type="checkbox"/> Pathology	<input type="checkbox"/> Radiology	<input type="checkbox"/> Medications	<input type="checkbox"/> Physician Orders
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Echo	<input type="checkbox"/> EKG	<input type="checkbox"/> EEG
<input type="checkbox"/> Pulmonary Function Test	<input type="checkbox"/> Sleep Study	<input type="checkbox"/> D/C Instructions	<input type="checkbox"/> If Other (Specify Below)
<input type="checkbox"/> *Drug Substance (initial) _____	<input type="checkbox"/> *Behavioral/Psychiatry (initial) _____	<input type="checkbox"/> *Lab-Sensitive/Genetics (HIV/STD/Drug Screen/Pregnancy) (signature required) X _____	
<input type="checkbox"/> <b>COMPLETE MEDICAL RECORD</b> (Not for Continuum of Care)			
<input type="checkbox"/> Include psychology/psychiatry records			
<input type="checkbox"/> Exclude psychology/psychiatry records			

OTHER (PLEASE SPECIFY):

PURPOSE AND NEED FOR DISCLOSURE  HEALTHCARE  THIRD PARTY PAYOR  PERSONAL  OTHER (PLEASE SPECIFY)

DATES OF HOSPITALIZATION OR TREATMENT

THIS AUTHORIZATION IS SUBJECT TO REVOCATION AT ANY TIME EXCEPT TO THE EXTENT ACTION HAS ALREADY BEEN TAKEN. THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE NINETY (90) DAYS FROM THE DATE OF MY SIGNATURE OR SOONER UNDER THE FOLLOWING CONDITIONS:

PATIENT'S SIGNATURE X	PHONE	DATE
PARENT, GUARDIAN, OR OTHER LEGAL REPRESENTATIVE X	RELATIONSHIP TO PATIENT	DATE
WITNESS X		DATE

AUTHORIZATION MUST BE SIGNED AND DATED BY THE PATIENT, PARENT OR LEGAL GUARDIAN/REPRESENTATIVE AND THIS SIGNATURE MUST BE WITNESSED. THE AUTHORIZATION MUST BE DATED SUBSEQUENT TO THE VISIT DATE REQUESTED. A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

I understand that this authorization will expire on \_\_\_\_/\_\_\_\_/\_\_\_\_.  
I understand that I may revoke this authorization at any time in writing before the expiration date, except to the extent that action has been taken in reliance on this authorization. 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.

### AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION



### Electronic Record Delivery Request

Complete this form, along with an AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION, to receive your medical records as electronic PDF files rather than as printed copies.

<b>Requester Name</b>					
	First		Last		
<b>Street Address</b>			Suite / Apt #		
	Street				
	City		State	Zip	
<b>Email Address for record delivery</b>					
<b>Medical Records Requested</b>					
<b>Patient Name</b>					
	First		MI	Last	
<b>Date of Birth</b>					
<b>Date of Service</b>					
	From		To		

Please provide me with the medical records described above through the CIOX Health eDelivery online service. I understand and agree that:

I must provide a valid email address, either my own or that of my designated recipient.

- My records will be provided as Adobe PDF files on CIOX Health’s eDelivery website.
- I will receive an email from **CIOXHealth.com** containing instructions for accessing my records.

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

Contact HIM/Release of Information with any questions @ 305-669-6412.