The Children's Hospital of San Antonio™
CHRISTUS Health

Authorization for the use and disclosure of health related information.

Patient Identification

Printed Name: _____ Date of Birth: _____

Address: _____

_____

Social Security #: _____ Telephone: _____

Information To Be Released – Covering the Periods of Health Care

From (date) _____ To (date) _____

Please check type of information to be released:

□ Complete health record	□ Diagnosis & treatment codes	□ Discharge summary
□ History and physical exam	□ Consultation reports	□ Progress notes
□ Laboratory test results	□ X-ray reports	□ X-ray films / images
□ Photographs, videotapes	□ Complete billing record	□ Itemized bill

□ Other, (specify) _____

Who and Where to Send / Release Information

The Children's Hospital of San Antonio
Goldsbury Center for Children's and Families
Genetics Clinic, 2nd Floor, Clinic 2C
333 North Santa Rosa Street
San Antonio, Texas 78207
210.704.0407

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I have been afforded the opportunity to sign a specific authorization.
***Initial One: Yes*_____ No_____ Not Applicable _____**

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I have been afforded the opportunity to sign a specific authorization.
***Initial One: Yes*_____ No_____ Not Applicable _____**

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at *100 NE Loop 410, Suite 800, SATX 78216.* Unless revoked, this authorization will expire on the following date or event _____, or 180 days from date of signature, unless otherwise specified.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form. I can inspect or copy the protected health information to be used or disclosed. **I authorize *The Children's Hospital of San Antonio* to use and disclose the protected health information specified above.**

Signature: ____ _____ Date: _____

Authority to Sign, if not patient: _____

Identity of Requestor Verified via**: □ Photo ID □ Matching Signature □ Other, specify** _____