

Authorization to Obtain and/or Release Protected Health Information ("PHI") Form

This form, if signed, will authorize Cook Children's Health Care System ("CCHCS") to obtain and/or release certain health information about the person named below. All items must be completed and the authorization signed and dated by an authorized person to be valid. I may refuse to sign this authorization and I understand that CCHCS may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

1. I authorize CCHCS (Please check all that apply):

Medical Center – Fort Worth Medical Center – Prosper Physician Name/Clinic Name: _____

Home Health; to obtain and/or release health information, as described below, from the medical record of:

Patient's Full Name: _____ DOB: _____

2. The information specified below may be obtained from and/or released to:

Name of person/organization Phone Number

Address, City, State, Zip Code Fax Number

3. Patient information is needed for (Please check all that apply):

- | | | |
|--|---|---|
| <input type="checkbox"/> Personal Use/Patient Access | <input type="checkbox"/> Military | <input type="checkbox"/> Social Security/Disability |
| <input type="checkbox"/> Marketing | <input type="checkbox"/> Insurance/Billing/Claims | <input type="checkbox"/> Education |
| <input type="checkbox"/> Continuing Medical Care | <input type="checkbox"/> Legal Purposes | <input type="checkbox"/> Other: _____ |

4. Must select one: I want OR I do not want the specified information to be released to include history, diagnosis and/or treatment for: Genetics, HIV/AIDS/testing, Communicable diseases, Drugs/Alcohol, Mental Health disease.

5. Information to be released and/or obtained (Please check all that apply):

Specify Dates of Service: _____

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Hospitalization Reports | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Face Sheet |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Emergency Room Record | <input type="checkbox"/> X-ray Images | <input type="checkbox"/> History and Physical |
| <input type="checkbox"/> Audio, PT, OT, Speech Evaluations | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Medical Information/Images for Marketing or Education | | |
| <input type="checkbox"/> Speciality Clinic Notes | <input type="checkbox"/> Other: _____ | | |

Approve Verbal Communication with Date of Visit Initials

6. I understand and acknowledge the following statements: I may be asked to show proof that I have the authority to sign this authorization. I may be charged a fee for any copies of my medical records or my child's medical records in accordance with federal and state regulations. I have the right to revoke this authorization at any time. Revocation must be made in writing to: **Cook Children's Health Care System, Health Information Management Department, 801 7th Avenue, Fort Worth, Texas 76104.** My revocation will not apply to information that has already been disclosed in response to this authorization. After the above medical information is released, it may be re-released by the recipient and the information may no longer be protected by federal privacy laws or regulations.

REVOCAION: Unless otherwise revoked in writing, this authorization is valid until the following specific date (optional): Month _____ Day _____, Year _____. For patients under the age of 18 at the time this authorization is signed, if no expiration date is indicated, this authorization is valid until the patient's 18th birthday. For patients who are 18 years of age or older at the time this authorization is signed, if no expiration date is indicated, this authorization will expire 2 years from the date this form is signed.

Printed Name of Patient/Parent or Legally Authorized Representative Relationship

Signature of Patient/Parent or Legally Authorized Representative Date Time

Description: ROIRequest



PRINT OR IMPRINT PATIENT INFORMATION

CSN: _____

MRN: _____



Language assistance services

English

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-682-885-4000 or speak to your provider.

العربية (Arabic)

تنبيه: إذا كنت تتحدث اللغة العربية، فستكون خدمات المساعدة اللغوية المجانية متاحة لك. وتتوفر أيضًا مساعدات وخدمات إضافية ملائمة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على 1-682-885-4000 أو تحدث إلى موفر الخدمة الخاص بك.

繁體中文 (Chinese)

注意: 如果您讲简体中文, 我们可为您提供免费的语言协助服务。还免费提供适当的辅助工具和服务, 以无障碍格式提供信息。请致电 1-682-885-4000 或与您的服务提供商联系。

Français (French)

À L'ATTENTION DE : Si vous parlez français, une aide linguistique gratuite est à votre disposition. Des aides auxiliaires et des services appropriés qui donnent des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-682-885-4000 ou parlez-en à votre prestataire.

Deutsch (German)

BITTE BEACHTEN SIE: Für den Fall, dass Sie Deutsch bevorzugen, stehen Ihnen kostenlos unterstützende Sprachdienste zur Verfügung. Dasselbe gilt für besondere Hilfsmittel und Hilfsdienste zur Bereitstellung von Informationen in zugänglichen Formaten. Bitte wählen Sie die 1-682-885-4000 oder wenden Sie sich an Ihren Gesundheitsdienstleister.

ગુજરાતી (Gujarati)

ધ્યાન આપો: તમે ગુજરાતી બોલતા છો, તો તમને ભાષાકીય સહાયતા માટે નિ:શુલ્ક સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પ્રદાન કરવા માટે ઉચિત પૂરક સહાય અને સેવાઓ પણ નિ:શુલ્ક ઉપલબ્ધ છે. 1-682-885-4000 પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

हिंदी (Hindi)

ध्यान दें: अगर आप हिंदी भाषी हैं, तो आपके लिए मुफ्त भाषा सहायता सेवाएं उपलब्ध हैं। सुलभ फॉर्मेट में जानकारी उपलब्ध कराने के लिए उपयुक्त सहायक साधन और सेवाएं भी मुफ्त में उपलब्ध हैं। 1-682-885-4000 पर कॉल करें या अपने प्रोवाइडर से बात करें।

日本語 (Japanese)

注意: 日本語を話される場合は、無料の言語アシスタンスサービスがご利用になれます。アクセスできる形式で情報を提供するための適切な補助器具やサービスも無料でご利用になれます。電話 (1-682-885-4000) またはプロバイダーにご相談ください。

한국어 (Korean)

주의: 한국어를 사용하는 경우 무료 언어 지원 서비스를 이용할 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구와 서비스도 무료로 제공됩니다. 1-682-885-4000으로 전화하거나 서비스 제공 업체에 문의하세요.

ພາສາລາວ (Laotian)

ແຈ້ງໃຫ້ຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາໄດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ ມີ ໃຫ້ທ່ານ ຊ່ວຍກ່ອນຊ່ວຍແລະບໍລິການທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ເຂົ້າໃຈ ງ່າຍ ກໍມີໃຫ້ໄດ້ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍເຊັ່ນກັນ ກະລຸນາໂທ 1-682-885-4000 ຫຼື ໃຫ້ ສືບທະນາກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ

فارسی (Persian)

توجه اگر به زبان فارسی صحبت می کنید، خدمات رایگان کمک زبانی برای شما فراهم می باشد. ابزارها و خدمات کمکی مناسب برای ارائه اطلاعات در قالب های قابل دسترس نیز به صورت رایگان در دسترس شما می باشند. با شماره 1-682-885-4000 تماس بگیرید یا با ارائه دهنده ی خدمات خود صحبت نمایید.

Русский (Russian)

ВНИМАНИЕ: Если вы говорите по-русски, вам доступны бесплатные услуги языковой помощи. Соответствующие вспомогательные средства и услуги для предоставления информации в доступных форматах также бесплатны. Позвоните 1-682-885-4000 или обсудите тему с поставщиком услуг.

Español (Spanish)

ATENCIÓN: si habla español, contamos con servicios gratuitos de asistencia lingüística para usted. Los servicios y las ayudas auxiliares apropiados para proporcionar información en formatos accesibles también están disponibles libre de costo. Llame al 1-682-885-4000 o hable con el profesional de salud que lo atiende.

Tagalog (Tagalog)

PAUNAWA: Kung nagsasalita ka ng Tagalog, mayroon kang magagamit na mga libreng serbisyo ng tulong sa wika. Mayroon ding mga naaangkop na auxiliary na tulong at serbisyo na magbibigay ng impormasyon sa mga accessible na format na magagamit nang libre. Tumawag sa 1-682-885-4000 o makipag-usap sa provider mo.

اُردُو (Urdu)

توجه فرمائیں: اگر آپ اردو بولتے ہیں، تو زبانی معاونت کی مفت خدمات آپ کے لیے دستیاب ہیں۔ معلومات فراہم کرنے کے لیے قابل حصول فارمیٹس میں موزوں اضافی امداد اور خدمات بھی مفت میں دستیاب ہیں۔ 1-682-885-4000 پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔

Tiếng Việt (Vietnamese)

NƠI NHẬN: Nếu quý vị nói Tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Các dịch vụ và hỗ trợ bổ sung thích hợp để cung cấp thông tin ở các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Gọi 1-682-885-4000 hoặc trao đổi với nhà cung cấp dịch vụ của quý vị.