



Authorization for Release of Medical Information

Health Information Management Dept.
Mon – Fri 8:30 am to 5:00 pm
111 Michigan Avenue, NW
Washington, DC 20010

Phone (202) 476-5267
Fax (202) 476-2270
Please forward your request to:
medicalrecords@childrensnational.org

Medical Record # (Office Use Only)

Date of Birth

Patient Name

Phone Number

Street Address

City, State, Zip Code

(1) I, the undersigned, hereby authorize Children’s National Medical Center to use and/or disclosure the above named individual’s health information to:

Name of Person and/or Agency

Phone Number

Street Address

City, State, Zip Code

(2) Provide the records by means of:

- Mail
- E-Mail

CD (Personal requests-After 100 pages;
Attorney requests-After 60 pages)

Fax (Immediate Patient Care
Only)_____

(3) Date of Service (specify dates or a date range): _____ to _____ and for the purpose of:

- Continued Medical Care
- School

Self

Other: _____

(4) Release the following information (check all applicable information to be released):

- Abstract/Summary
- Immunization Record
- Well Child
(Physicals & School Forms)
- Emergency Room Records
- Outpatient Reports
- Inpatient
- History and Physical Reports
- Discharge Summary Reports
- Laboratory Results
- Radiology Results ***
- Dental Records ***
- Psychiatric Treatment Records, Psychotherapy Notes
(requires dept. approval)
- Other _____
- All Records

***For Radiology films/images, please call (202) 476-3426
***For Dental Records, please call (202) 476-2160

Fees for personal requests: 1-4 pages **FREE**, 5 pages or more **FLAT rate** of \$6.50

- (5) I understand the above named individual’s health information may include information relating to sexually transmitted diseases, genetics, sexual activity including contraceptive methods, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) where applicable. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse in accordance to 42 CFR Part 2.
- (6) I understand that I have the right to revoke this authorization at any time. If I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to process a claim under my policy. **This authorization will expire within six months** unless otherwise revoked for the following date, event, or condition: _____.
- (7) I understand that authorizing the disclosure of this health information is voluntary. I understand that there are fees associated with redisclosures excluding for direct patient care (i.e. practitioner to practitioner communication). I understand that I may inspect the information to be used or disclosed as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized redisclosures and the information may not be protected by federal confidentiality rules.
- (8) ****PSYCHIATRIC TREATMENT:** This authorization does not apply to any mental health information obtained after the signed date of the authorization below. The unauthorized disclosure of mental health information violates the provisions of the District of Columbia Mental Health Information Act of 1978. Disclosure may be made pursuant to a valid authorization by the client or as provided in Title III or IV of the Act. The Act provides for civil damages and criminal penalties for violation.
- (9) I, do hereby, declare that I am the patient/parent/legal guardian and am responsible for the release of information with regard to the above named patient. (Appropriate documentation will need to be provided with authorization in order to process release). **NOTE: If patient is of legal age (18), patient will need to sign the release themselves.**

Signature of Patient

Signature of Parent or Legal Guardian

Date

Email Address

Print Name of Parent or Legal Guardian

Witness

