Authorization for Release of Medical Information

Children's National

Health Information Management
Mon – Fri 8:00am to 4:30pm
Phone (202) 476-5267
Fax (202) 476-2270

❑ 111 Michigan Avenue, NW
Washington, DC 20010

❑ 12200 Plum Orchard Drive, Suite 105
Silver Spring, MD 20904

_____
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
❑ CD *(Meaningful Use Requests Only)*
❑ Pick-up (select location above)
❑ Verbal Communication *(Provider to Provider Only)*
❑ 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)*:

❑ Problem List
❑ Medication List
❑ Immunization Record
❑ Ambulatory Treatment Records (clinic visits)
❑ Emergency Room Records
❑ Outpatient Reports
❑ Consultation Reports
❑ History and Physical Reports
❑ Discharge Summary Reports
❑ Laboratory Results
❑ Radiology Results ***
❑ Psychiatric Treatment Records ** *(requires dept approval)*
❑ Other: _____

****For Radiology films/images, please call (202) 476-5073*

(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 month** 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). **Fee for copies are $0.39/pg+postage when applicable* 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

-MEDREC7-

Children's National Medical Center

CONSENT FOR INTER-FACILITY TRANSPORT, TREATMENT, AND RELEASE OF INFORMATION

Addressograph Label

DO NOT WRITE IN THIS BOX

I hereby consent to the transport and treatment of _____ *(patient) by the Children's National Medical Center Pediatric/Neonatal Transport Team operated by LifeStar Response Corp or via* _____.

TRANSPORT TYPE:

_____I understand that said patient is being transported to Children's National Medical Center for treatment.

_____I understand that said patient is being transported to _____ for _____.

I understand that this transfer may be accomplished via ambulance or aircraft with or without a physician in attendance.

RISKS, BENEFITS, AND ALTERNATIVES:

I understand that there may be additional risks associated with transporting a patient via ambulance, helicopter, or fixed wing aircraft. I understand that the general risks listed below apply to all vehicle occupants, including parents/guardians accompanying the transport. The risks of transport may include but are not limited to the following:

- The general risks associated with emergency medical transportation, such as possible failure of equipment, aircraft, or vehicle; vehicle or aircraft accident; traffic hazards; adverse weather conditions; or consequences of actions of persons outside the control of transport personnel.
- Risks associated with all medical transport, including the possible worsening of the patient's condition during transport or the interruption of medical treatment during transportation, which could result in death, brain damage or serious bodily injury.

I understand that the benefits of transfer may include care in a specialized pediatric facility with pediatric specialists, communication with physicians while in transit, or other services that meet the special care needs of said patient.

I have been told about reasonable alternatives to the proposed care, treatment, and service, which may include remaining at the referring facility. I have been informed about the benefits, if any, of choosing an alternative to the proposed transfer.

I have been informed about the relevant risks, including death, brain damage or possible worsening of said patient's condition by choosing an alternative to the proposed transfer.

RELEASE OF INFORMATION:

I give my permission to Children's National Medical Center to release information, verbally or in writing, to the referring and the receiving hospital/facility. I understand that this includes information contained in the medical records pertaining to this patient during inter-facility transport and hospitalization.

TRCT

TREATMENT BY TRANSPORT TEAM:
I authorize the members of the medical transport team to perform all treatments and emergent procedures they deem necessary during the transport and immediately upon arrival at the accepting facility.

CONSENT:
I understand the risks and benefits associated with inter-facility transport. I accept the opinion of the referring physician and receiving physician (or designee) that said patient's condition justifies transport to _____ for further evaluation and/or treatment. I authorize transportation by surface and/or air ambulance.

_____ _____ _____
Signature Print Name Date

_____ _____
Relationship to Patient Telephone Number

_____ _____
Witness Date

RISKS FOR VEHICLE PASSENGERS SUCH AS PARENT/GUARDIAN/FAMILY:
I understand that there may be additional risks associated with accompanying a patient via ambulance, helicopter, or fixed wing aircraft. The risks of transport may include but are not limited to the following:

- The general risks associated with emergency medical transportation, such as possible failure of equipment, aircraft, or vehicle; vehicle or aircraft accident; traffic hazards; adverse weather conditions; or consequences of actions of persons outside the control of transport personnel. Such vehicle accidents or incidents could lead to personal injury or death.
- I understand that my signature below means that I assume any and all risks associated with my decision to accompany my child or any child via ambulance, helicopter or fixed wing aircraft.
- I also understand that my signature below means that I am free to accompany my child or not accompany my child and I waive any claims for liability against CNMC which may arise out of my decision to accompany my child (or any child).

_____ _____ _____
Signature of Individual Accompanying Transport Print Name Date

_____ _____ _____
Relationship to Patient Telephone Number Witness

SPECIAL CONSENT CIRCUMSTANCES:
___The above consent was read to the consenting person.
___The above consent was read to the consenting person by interpreter _____(Interpreter signature).
___The above information was discussed by telephone with the consenting person by the individual signing below (print name and telephone number of consenting person and indicate relationship above).
___Parent/guardian not available to consent. Authorization for transport by referring physician or designee (print and sign name of referring physician and witness below).

_____ _____ _____
Name Signature Date

_____ _____ _____
Witness Name Witness Signature Date

Children's National Medical Center

CONSENTIMIENTO PARA TRANSPORTAR ENTRE CLÍNICAS U HOSPITALES, TRATAMIENTO, Y LIBERACIÓN DE INFORMACIÓN

Addressograph Label

DO NOT WRITE IN THIS BOX

Por este acto doy mi autorización para que el Equipo de Transporte Neonatal/Pediátrico de Children's National Medical Center operado por LifeStar Response Corp o por_____provea transporte y tratamiento para_____.

TIPO DE TRANSPORTE:

_____Entiendo que el paciente será transportado por Children's National Medical Center para su tratamiento.

_____Entiendo que el paciente será transportado a _____para _____.

Entiendo que este traslado se puede hacer en una ambulancia o en un vehículo aéreo con o sin asistencia médica.

RIESGOS, BENEFICIOS Y ALTERNATIVAS:

Entiendo que transportar pacientes en ambulancia, helicóptero o vehículo aéreo de ala fija puede conllevar otros riesgos, tales como:

- Los riesgos generales relacionados con el transporte médico de emergencia, como falla del equipo, la falla del vehículo terrestre o aéreo, accidentes, peligros relacionados con el tráfico, condiciones de clima adverso, o consecuencias de los actos de las personas que están fuera del control del personal de transporte.
- Los riesgos relacionados con el transporte médico, como que empeore la condición del paciente o la interrupción del tratamiento médico durante la transportación, lo que podría causar la muerte, daño cerebral o lesiones graves.

Entiendo que los beneficios del traslado incluyen el cuidado en una instalación pediátrica con especialistas en pediatría, la comunicación con los doctores durante la transportación u otros servicios que satisfagan las necesidades especiales del cuidado de dicho paciente.

Me informaron de alternativas razonables al cuidado, el tratamiento y el servicio propuestos, como permanecer en la instalación donde el paciente se encuentra.

Se me informó de los beneficios, si los hay, de elegir una alternativa a la transferencia que se me propuso. Se me informó de los riesgos relevantes, como la muerte, el daño cerebral, o que empeore la condición del paciente al elegir una alternativa a la transferencia que se me propuso.

TRCT

REVELACIÓN DE INFORMACIÓN:
Le doy mi permiso a Children's National Medical Center para revelar información de manera verbal o escrita a los hospitales o clínicas de origen y de destino. Tambien entiendo que esta información puede ser la de los registros médicos relacionados con este paciente durante la transportación entre clínicas y la hospitalización.

TRATAMIENTO POR PARTE DEL EQUIPO DE TRANSPORTE:
Autorizo a los miembros del equipo de transporte médico para que brinden el tratamiento y los procedimientos de emergencia que consideren necesarios durante el transporte e inmediatamente al llegar a la clínica u hospital de destino.

CONSENTIMIENTO:
Entiendo los riesgos y los beneficios relacionados con la transportación entre clínicas u hospitales y acepto la opinión de los doctores que envian al paciente y a quienes lo reciben (o las personas que éstos designen) de que su condición justifica su transportación a _____ para su evaluación y/o tratamiento. Asimismo, autorizo que el transporte se haga por tierra y/o por aire.

_____ _____ _____
Firma Nombre (use letra de molde) Fecha

_____ _____
Parentesco con el paciente Teléfono

_____ _____
Testigo Fecha

CIRCUNSTANCIAS ESPECIALES DEL CONSENTIMIENTO:

___ Se le leyó el consentimiento anterior a la persona que autoriza.
___Un intérprete tradujo el consentimiento anterior para la persona que autoriza
_____ (Firma del intérprete).
___La persona que autoriza y la persona que firma más adelante (nombre y teléfono de la persona que autoriza con letra de molde. Indique el parentesco arriba) comentaron la información anterior por teléfono.
___El padre o tutor no pudo dar su consentimiento. El doctor que envia al paciente o la persona que éste designe (proporcione nombre y firma del doctor y el testigo con letra de molde) da su autorización para la transportación del paciente.

_____ _____ _____
Nombre Firma Fecha

_____ _____ _____
Nombre del testigo Firma del Testigo Fecha

TRCT