0 2 2 8

THE UNDERSIGNED HEREBY AUTHORIZES NICKLAUS CHILDREN'S HOSPITAL 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

☐ Face Sheet	☐ History & Physical	☐ PT/OT/ST	☐ Immunizations
☐ Discharge Summary	☐ Consultations	☐ Operative Report	☐ Lab
☐ Pathology	☐ Radiology	☐ Medications	☐ Physician Orders
☐ Progress Notes	☐ Echo	☐ EKG	☐ EEG
☐ Pulmonary Function Test	☐ Sleep Study	☐ D/C Instructions	☐ If Other (Specify Below)
☐ *Drug Substance (initial) ___________	☐ *Behavioral/Psychiatry (initial) ___________	☐ *Lab-Sensitive/Genetics (HIV/STD/Drug Screen/Pregnancy) (signature required) X ___________	

☐ **COMPLETE MEDICAL RECORD** (Not for Continuum of Care)
***A $1 PER PAGE WILL BE CHARGED FOR THE COMPLETE MEDICAL RECORD. (FLORIDA STATUE.395.3025)*

OTHER (PLEASE SPECIFY):

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

DATES OF HOSPITALIZATION OR TREATMENT

THIS CONSENT IS SUBJECT TO REVOCATION AT ANY TIME EXCEPT TO THE EXTENT ACTION HAS ALREADY BEEN TAKEN. THIS CONSENT 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.

CONSENT FOR RELEASE/REQUEST OF INFORMATION

NICKLAUS CHILDREN'S HOSPITAL
MIAMI, FL 33155
FORM # 798.076.0228 (NURS0228)
Rev. 10/22/2014