NORTON HEALTHCARE

NORTON Children's Medical Group
Affiliated with SCHOOL OF MEDICINE

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I HEREBY REQUEST A COPY OF THE FOLLOWING PATIENT'S MEDICAL RECORD:

1. **Full Name of Patient**: _____ **Social Security#** _____

2. **Maiden Name/Alias:** _____ **Patient's Birth Date:** _____

3. **INFORMATION REQUESTED (X):** ( ) Medical Record ( ) Psychiatric Records ( ) Itemized Bills
   ******If only a portion of the Medical record or Psychiatric record is required please specify *******

4. ( ) Discharge Summary ( ) Emergency Room ( ) Laboratory Results
   ( ) History & Physical ( ) X-Ray Report ( ) Immunization Records
   ( ) Orders ( ) Operative Reports ( ) Progress Notes
   ( ) HIV Test/Status ( ) Nurses Notes
   ( ) Other (Specify)* _____

5. **IDENTIFY THE FACILITY WHERE THE PATIENT WAS TREATED (X):**
   ( ) Norton Healthcare - specify Hospital: _____
   ( ) Norton Cancer Institute, specify location: _____
   ( ) Norton Community Medical Associates, specify location: _____
   ( ) Norton Children's Medical Associates, specify location: _____
   ( ) Norton Immediate Care Center, specify location_____
   ( ) University of Louisville Physicians – Pediatrics _____
   ( ) Other, specify location: _____

6. **Identify date of service or date ranges requested including month and year:** _____

7. **Receive records via (Circle one):** MyNortonChart CD via mail Paper records via Mail

The above record is to be released/mailed to the following individual:

8. Name & Title: Records Deposition Service
   Street Address: P.O. Box 5054
   City/State/Zip: Southfield, MI 48086-5054 Phone Number: (248) 357-3330

9. **THIS RECORD IS REQUESTED FOR THE FOLLOWING REASON (X):**
   ( ) Continued Medical Care (✔) Legal Purposes ( ) Insurance Purposes
   ( ) Personal Interest ( ) Other (Specify)_____

The authorization must be signed and dated and may be revoked by notifying Hospital's Health Information Department in writing at any time except to the extent action has been taken prior to revocation. This consent will expire 60 days after the date beside my signature.

Kentucky Law directs health care providers to furnish to a patient, at the patient's request, one free copy of the patient's Medical Record.
I understand that the medical record released pursuant to this authorization could contain information concerning drug related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or blood borne infectious disease, which are subject to federal and/or state restrictions on disclosure. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. I hereby affirm that I have read and fully understand the above statements and consent to the disclosure of the medical record for the purpose and extent stated above.

If Norton Healthcare is asking to use/disclose my information, I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, enrollment in any health plan, or payment/benefit eligibility. I may inspect or copy any information used/disclosed under this authorization.

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10. **Signature** _____ **Date**_____
    Patient, Parent or Legally Authorized Representative

Relationship to the Patient: _____ Phone Number_____

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentially is protected by federal and/or state law. Federal and state regulations prohibits you (the recipient) from making any further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

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Legally Authorized Representative Questionnaire

Note: To be completed only if requesting the records of a minor or another adult for whom you are the legal representative.

Request for Copies of Medical Record of Minor Patient:

Authorization for the release of medical records may be provided by the custodial parent or legal guardian of the minor patient. Please check the box that designates your authority to sign for the release of the requested medical records:

- ☐ I share joint legal custody of the child for which I am requesting records. Must provide custody papers.
- ☐ I have sole custody of the child for which I am requesting records.
- ☐ I am the Legal Guardian for the child to which I am requesting records. The Legal Guardian must present an order of appointment, signed by a judge, granting him/her guardianship of the minor
- ☐ Married, custody not applicable.

Request for Copies of Medical Record of Adult Patient:

If you are requesting the medical record of an adult patient, other than yourself one of the following relationships must apply. Please check the box designating your rights to authorize release of the requested medical records.

- ☐ Power of Attorney (POA): Must complete and sign the medical record request form and provide a copy of the POA document.
- ☐ Legal Guardian: Must complete and sign the medical record request form and present an order of appointment, signed by a judge granting him/her guardianship of the patient
- ☐ Executor/Administrator of the adult deceased patient's estate. Must complete and sign the medical record request form and provide a copy of the qualification or order of appointment, signed by a judge as the executor or administrator over the estate.
- ☐ Personal Representative – a copy of the death certificate maybe requested

_____ _____

Signature of Parent or Legal Representative Date

_____ _____

Name of Parent or Legal Representative (please print) Phone Number