TO: ____
(Facility Name)

THE UNDERSIGNED HEREBY AUTHORIZES MIAMI 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:

SPECIFY TYPE OF INFORMATION TO BE DISCLOSED AND DATE OF SERVICE

PURPOSE AND NEED FOR DISCLOSURE

❑ HEALTHCARE ❑ THIRD PARTY PAYOR ❑ OTHER (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		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/REPRESENTATIVEAND 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 Miami Children's Hospital prior to receipt of the revocation.

CONSENT FOR RELEASE/REQUEST INFORMATION

MIAMI CHILDREN'S HOSPITAL
3100 S.W. 62nd Avenue
MIAMI, FL 33155
FORM # 798.076.228 (NURS228)