Phone: 703-481-5801 Fax: (703) 481-5804

CHILDREN'S HEART INSTITUTE

Release of Information

*All items with an asterisk are MANDATORY fields.

*Patient Name_____ *DOB _____

*Contact Phone Number _____

*Patient Address _____

Street Address **City** **State** **Zip Code**

***I authorize CHI to release or disclose the following information to:**

- ☐ Physician Phone # _____ Fax #_____
- ☐ Personal Mail Pick-up Fax#_____
- ☐ Legal Phone #_____ Fax #_____
- ☐ Disability Phone # _____ Fax # _____
- ☐ Other (Please specify) _____

Release copies of the following record:

- ☐ Complete Medical Records (Date(s)) _____
- ☐ EKG's
- ☐ Echo's, Tilt, Auto, Stress, Holter or Events
- ☐ X-rays
- ☐ Cauterizations
- ☐ TEE's
- ☐ Laboratory Reports

Note(s):

Fees + Postage (if applicable):

Pages: 1-50: $25.00 **Pages: 51 -100 $50.00** **Pages: + 100 $100.00**

Paid: _____

I understand if the person or agency that receives my information is not a health care provider of health plan covered by the HIPAA privacy regulations, the information described above may be re-disclosed and is no longer protected by these regulations.

I understand written notification is necessary to cancel this authorization. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization.

_____ _____

*Signature of Patient or Authorized Representative *Date

CHI Staff Signature Received Date Processed Date