RELEASE OF INFORMATION

Children's Heart Institute

Fax: 540-667-3874 Phone #: 703-724-4003 Or you can email the completed form to dmancuso@chiva.us

*All items with an asterisk are MANDATORY fields.

*Patient Name_____ *DOB _____

*Contact Phone Number _____

*Patient's Address _____
Street Address City State Zip Code

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

- ☐ Physician Name:_____ Phone #: _____
  . Fax #: _____
- ☐ Personal Mail or Pick up or 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 Table, Autonomic, Stress, Holter or Events
- ☐ X-Rays
- ☐ Cauterizations
- ☐ TEE's
- ☐ Laboratory Reports

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 HIPPA 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