MEDICAL RECORDS REQUEST

Snyder Family Cleft & Craniofacial Center at Wolfson Children's Hospital

836 Prudential Drive Suite 807, Jacksonville, Fl. 32207 • 904-202-4081 phone • 904-202-3699 fax

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize Snyder Family Cleft & Craniofacial Center at Wolfson Children's Hospital to use and/or disclose my protected health information (PHI) as provided below. I understand that I may revoke this authorization, but the revocation will not apply to information that has already been released in response to this authorization. The written revocation letter must be sent to Snyder Family Cleft & Craniofacial Center at Wolfson Children's Hospital. I understand that my child's treatment is in no way conditioned on whether or not I sign this authorization. I understand that once the PHI listed below is used or disclosed as set forth in this authorization, it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations.

Patient Name _____ Date of Birth _____

Parent/Guardian Completing Form (Please Print) _____

Patient Address _____

City _____ State _____ Zip Code _____ Phone ( ) _____

FILL OUT FOR SNYDER FAMILY CLEFT & CRANIOFACIAL TO OBTAIN RECORDS:	**FILL OUT FOR SNYDER FAMILY CLEFT & CRANIOFACIAL TO DISCLOSE:**
I authorize _____ To disclose health information to: Snyder Family Cleft & Craniofacial Center 836 Prudential Drive Suite 807 Jacksonville, Fl. 32207 Contact Person: _____ Telephone: _____ Fax: _____	I authorize Snyder Family Cleft & Craniofacial Center to disclose health information to: Facility/Name: _____ _____ Address: _____ _____ Telephone: _____ Fax: _____
THE PURPOSE OF THIS DISCLOSURE OR USE IS: ☐ MEDICAL ☐ AT THE REQUEST OF PATIENT	METHOD OF DISCLOSURE: ☐ MAIL ☐ FAX

This request and authorization applies to:

☐ Healthcare information related to the following treatment, condition or dates: Any and all records related to Cleft/craniofacial care, birth records, surgical records, discharge summaries, immunization records, and dental x-rays.

☐ Other: _____

I understand that state law prohibits the use and/or disclosure of the PHI listed below unless specifically authorized. I understand that such information will not be used or disclosed in response to the above request unless indicated by initialing below:

Mental/Psychiatric: (initial)_____ HIV Tests/Related: (initial)_____ Alcohol/Substance Abuse: (initial)_____

THIS AUTHORIZATION AUTOMATICALLY EXPIRES TWO (2) YEARS AFTER IT IS SIGNED OR UNTIL I REVOKE IT IN WRITING TO THE SNYDER FAMILY CLEFT & CRANIOFACIAL CENTER AT WOLFSON CHILDREN'S HOSPITAL.

PATIENT/PARENT/GUARDIAN SIGNATURE: _____ DATE: _____