

CHILDREN'S HEALTHCARE OF ATLANTA  
CHILDREN'S HEALTHCARE OF ATLANTA CARDIOLOGY  
AUTHORIZATION TO RELEASE/OBTAIN PROTECTED HEALTH INFORMATION

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**PATIENT INFORMATION:** Please insert the full legal name specific to the patient for whom information is being requested.

**SENDING ORGANIZATION:** Identify which Children's Healthcare of Atlanta Hospital or Clinic you are seeking information. Please be specific in your request. If you do not specify a hospital or clinic, records may be provided from ALL Children's Healthcare of Atlanta hospitals and clinic locations.

If authorizing Children's Healthcare of Atlanta to obtain information from another facility on your behalf, please include the full name of the person/business, phone number, fax number and as much additional contact information as possible.

**RECEIVING PERSON/ORGANIZATION:** Identify the full name of the person/business, address, and phone of the entity receiving the information.

**INFORMATION TO BE RELEASED:** This section gives us the instructions on what information is to be released. If you select "Routine Record Set", we will disclose the documents that are specific to the patient care visit. This is typically what doctors' offices, hospitals or other healthcare providers need to provide information related to your care. If you select "Any and All Records", your entire record will be provided for a specific visit date or all dates. It is very helpful if you identify the date or range of dates needed by the requester.

**RELEASE INSTRUCTIONS:** This tells us how you would like your information delivered. We can print the documents, create a CD or, you may set up an appointment for viewing. If you wish to view information prior to selection of documents, please identify this on the authorization form and we will contact you to set up a viewing appointment. It is Children's Healthcare of Atlanta's policy NOT to fax or email patient information except for direct patient care requirements (e.g. to a doctor or clinic). *Please note:* If you select "verbal" release, you are permitting Children's Healthcare of Atlanta to discuss and disclose confidential Protected Health Information (PHI) with the named recipient. Only clinical staff is permitted to verbally release PHI.

**PURPOSE OF THE REQUEST:** Please identify the reason why a copy of the patient record is needed. This helps us to track and assign a priority status to your request. It also informs us who may be responsible for the cost of records (where appropriate).

**DURATION OF CONSENT, REVOCATION AND OTHER INFORMATION YOU NEED TO KNOW:** This consent will automatically expire in 12 months UNLESS you write some other date or event. The authorization is revoked at your written direction to our organization.

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Contact Information for Patient Record Copies

Children's Healthcare of Atlanta Cardiology  
Information Services  
2835 Brandywine Road  
Suite 400  
Atlanta, GA 30341  
Phone: 404-256-2593  
Fax: 770-488-9403  
HIS@kidsheart.com

For a list of Children's Healthcare of Atlanta Cardiology locations and addresses please visit:  
**[www.choa.org/heart](http://www.choa.org/heart)**

