21` Ventilator Assisted Children's Home Program (VACHP)

Request and Authorization to Release, use and/or Share Medical Information

New Federal Privacy Laws require us to obtain parent legal guardian permission to release, use and/or share patient medical information.

This form must be used for the following:

1. When a patient requests a release of information and/or;
2. To authorize Ventilator Assisted Children's Home Program staff to use and/or share Information for fundraising, marketing or other internal purposes except treatment, payment or operations. I understand that this permission is voluntary.

1. **Patient Information and Statement:** I give my authorization/permission for Ventilator Assisted Children's Home Program (VACHP) to release, use and/or share the medical information described below. I understand that once this information is release, used and/or shared, the person or organization that received it may share it again. If this happens, the information may no longer be protected under applicable privacy laws. I understand what type of information is going to be released, used and/or shared and how this is going to be done.

Patient Name (First, Middle, Last): ____
Patient Address: ____
City, State, Zip: ____
Telephone Number: ____
Patient Date of Birth: ____

2. **Records To Be Released, Used and/or Shared:**
   Please indicate the sections(s) of the record below that you would like released or that you permit us to use and/or share.

Emergency Department Records __________________ Date(s) of Service: ____________
Home Care Records ____________________________ Date(s) of Service: ____________
Immunization Records __________________________ Date(s) of Service: ____________
Inpatient Records ______________________________ Date(s) of Service: ____________
Outpatient Records _____________________________ Date(s) of Service: ____________
Other Records _________________________________ Date(s) of Service: ____________

Of the records noted above, please list any areas of those records that you do not wish us to release, use and/or share: ____

If the medical record contains any of the following information, may we release, use and/or share it?
If you answer yes, please write your initials next to each type of information listed here:

Drug and/or alcohol treatment or testing ______________
HIV ________________
Mental Health Information ________________

(A separate form is required for notes taken at a psychotherapy session)

3. Please Send/Give My Information To:
Name (First, Middle, Last): ____
Address: ____
City, State, Zip: ____
Telephone Phone Number: ____
Fax Number: ____

4. Time Limit. What is the time limit for this permission?
______________________________________Please note, the date you give us cannot be more than 90 days from now)

5. What Is the Reason For Releasing, Using and/or sharing This Information? The information will be released, used and/or shared for these specific reasons:

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I understand that I may revoke (withdraw) my permission at any time. If I wish to withdraw my Permission, I must put this request in writing and sent it to:
Ventilator Assisted Children's Home Program (VACHP)
100 N. 20th Street, Suite 201
Philadelphia, PA 19103

I understand that if I send a letter withdrawing my permission, that letter cannot bring back any information that was already released, used and/or shared. I also understand that it will take time for The Ventilator Assisted Children's Home Program to receive and process my request.

Signature of Patient/parent/Legal Guardian: _________________________Date: ________

If a person cannot provide a written signature, two witnesses must sign below:

Witness: _____________________________ Date: _____________________________

Witness: _____________________________ Date: _____________________________

Signature of VACHP Staff Member: __________________________ Date: ____________