Form Approved
OMB NO. 0920-0741
Exp. Date 6/30/2010

Study to Explore Early Development

***Health Insurance Portability and Accountability Act (HIPAA)* Medical Records Release Authorization Form**

Patient Name:			
Phone(s):		**Street Address:**	
Date of Birth:		**SS # (last 4 digits):**	

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. I authorize the following individuals and/or organizations to make this disclosure.
   Medical Provider (name & address):

The information identified below may be used by or disclosed to the following individuals/organizations:

Name: << ***site specific information***>>

Address: << ***site specific information***>>

3. ☐ **I Authorize Release of <u>the ENTIRE medical record without exception</u>** .

NOTE: If you do not want to have your entire record reviewed, please check #4 below and select the types of information that you are willing to provide.

4. ☐ I Authorize Release of PARTIAL medical records**.** If parents do not wish to reveal the entire record: **Please specify the parts and dates to be released below**.

Dates of Service:

Types of Information
(Check all that apply below. ***It is NOT necessary to check the boxes below, unless you disagree with statement #3 above)*:**

☐ Gynecology & Obstetric Records	☐ Face Sheets/Registration Sheets	☐ Pathology Report
☐ Labor and Delivery Record	☐ HIV Information	☐ Post-Operative Reports
☐ Pediatric Record	☐ Hospital Admissions Information	☐ Procedural Information
☐ Anthropometric (growth) measurements	☐ Injection/Vaccination Information	☐ Progress Notes
☐ Consultation Reports	☐ Lab Results	☐ Radiology (Ultrasound) Reports
☐ Discharge Summary/Instructions	☐ Medication List	☐ Referral Sheets
☐ ER (emergency room) records	☐ Medical History	☐ Substance Abuse Information
	☐ Mental Health Information	☐ Surgical History
		☐ ____________________

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Public Reporting Burden Statement

Public reporting burden of this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0741)

5. The information that I am authorizing for this disclosure will be solely used for the purpose of the Study to Explore Early Development, an epidemiologic research study.

6. I understand that I have a right to revoke this authorization at any time. If I choose to revoke this authorization, I must do so in writing, and submit my written request to the medical records department of this facility. I also understand that any information that the researchers collect before I choose to revoke this authorization will be retained by the researchers.

7. I understand that unless revoked, this authorization will expire at the end of the Study to Explore Early Development (SEED) case cohort research study.

8. I understand that because sensitive information is collected in this study, **<<*site name*>>** received a **Certificate of Confidentiality**. This means that any information that **<<*site name*>>** has that identifies me or my child will be used only for this project. It **cannot be given, used, or disclosed** to anyone else unless I give my written consent (or unless required by law).

9. I understand that this disclosure is voluntary and my decision to authorize or not authorize the release of this information will not affect my ability to be treated at the above mentioned facilities.

Patient (or legal representative) Signature		Date
If signed by legal representative, relationship to patient		
Signature of Witness (for SEED staff)		Date