

Authorization to Release Information about Medical Records

Name of Hospital and/or Clinic _____

Contact information for Child's Physician:

Name: _____

Address: _____

Telephone #: _____

Child's Name: _____
Last First Middle Initial

Child's Date of Birth: _____
Day/month/year

Child's Address: _____

Child's Telephone #: _____

Parent's Name: _____
Last First Middle Initial

Child's Social Security Number*: _____

(*Your child's social security number will be used only for the purposes of getting information from insurance claims, medical records, and databases that are available to the public. It will not be used for any other purposes and will be kept confidential).

Name of Organization Authorized to Receive Information:

Clinical Immunization Safety Assessment Centers

I authorize the clinic/hospital and the physician listed above to release the information specified below to BUMC and Clinical Immunization Safety Assessment Center(CISA). I specifically authorize the release of the following: Insurance claims data and medical records including charts, x-rays, and laboratory work about illnesses my child may have had during the period from birth unit until present.

I give my permission for this information to be used for the purposes of CISA adverse event consultation. I do not give permission for any other use or further disclosure of this information.

I agree that this authorization is valid for 36 months from the date I have signed this agreement. A photocopy or facsimile of this authorization is approved as the original. I understand that I may revoke this authorization at any time by contacting CISA staff.

You will receive a signed copy of this authorization form.

Signature of Parent/Legal Guardian Date

Signature of Person Conducting Interview Date