

**Autorización para el Uso o Revelación de
Información Psicológica o Psiquiátrica
(Atrás)**

8071-171S MR 08/07 (translated 11/3/05)



STAFF USE ONLY / SOLO PARA EL USO DEL PERSONAL:

This consent complies with policies of The Children’s Mercy Hospital that require written consent to exchange information. This consent is intended for use throughout Children’s Mercy.

With any necessary assistance from the initiating staff member, an “authorized” individual (as defined by applicable policies and/or procedures) will complete this form to request the release of medical information from The Children’s Mercy Hospital to an outside person or facility, OR from an outside person or facility to The Children’s Mercy Hospital.

STAFF INSTRUCTIONS:

1. Assist the patient and parent/legal guardian as necessary in completing this form properly and in its entirety.
2. Assure that the patient and parent/legal guardian understand that this consent is applicable until the disclosure is complete, unless they revoke it sooner.
3. Confirm the following:
 - Patient information (name, address, etc.) is complete.
 - The appropriate items for release have been checked.
 - Purpose for information is explained.
 - It is clear who is to release and who is to receive information – appropriate boxes are checked and location and/or person are specified in the appropriate blank(s). (This will determine how consent is processed – see #4 below.)
 - The authorizing individual has signed and dated the consent.
4. If information is to be *released from an outside agency or person* to The Children’s Mercy Hospital, the parent/legal guardian will keep the completed form (or may take the blank form home to complete). He or she is responsible for taking the original to the outside agency or person. (A copy will typically be sent with any information released to The Children’s Mercy Hospital.
5. If information is to be *released by The Children’s Mercy Hospital*, give the parent/legal guardian the yellow copy of the completed form. If necessary, he or she will make that copy available to the outside agency or person receiving information. He or she will take necessary action, and sign and date the bottom of the front page. (The Medical Records department will file the original in the medical record.
6. Follow up as needed in your department and document according to applicable policies and procedures.

The Children’s Mercy Hospital Locations

(Place ID in appropriate blank for #3 or #4 on front.)

<u>ID</u>	<u>Location</u>	<u>Address</u>	<u>Telephone #</u>
MR	Medical Records Department	2401 Gillham Road, Kansas City, MO 64108-4619	(816) 234-3455 FAX: (816) 234-3458
NOR	Children’s Mercy Northland	501 NW Barry Road, Kansas City, MO 64155-2732	(816) 413-2500
SOU	Children’s Mercy South	5808 West 110 th Street, Overland Park, KS 66211-2504	(913) 696-8000 FAX: (913) 696-8260
SPC	CMH Specialty Center	5808 West 110 th Street, Overland Park, KS 66211-2504	(913) 696-8220 FAX: (913) 696-8260
PPO	Children’s Mercy West / The Cordell Meeks Jr. Clinic	4313 State Avenue, Kansas City, KS 66102	(913) 233-4400 FAX: (913) 287-0132
CMHC	Children’s Mercy Home Care	1900 West 47 th Place, Suite 330, Westwood, KS 66205-1802	(913) 696-8999
SCHSC	Children’s Mercy South Hearing & Speech Clinic	5520 College Blvd., Suite 360, Overland Park, KS 66211-1630	(913) 696-8844
DEV	CMH Section of Developmental & Behavioral Sciences	2401 Gillham Road, Kansas City, MO 64108-4619	(816) 234-3674
CARE	CMH CARE Clinic	2401 Gillham Road, Kansas City, MO 64108-4619	(816) 234-3424
SCCAR	Children’s Mercy South Cardiology Clinic	5520 College Blvd., Suite 360, Overland Park, KS 66211-1630	(913) 696-8700

****IF LOCATION OR PERSON IS NOT LISTED, SPECIFY IN BLANK PROVIDED ON FRONT.**



Autorización para el Uso o Revelación de Información Psicológica o Psiquiátrica (Frente)

8071-171S MR 08/07 (translated 11/3/05)

Yo autorizo el uso o la revelación de información especificada en esta autorización con respecto al siguiente individuo:

Nombre del paciente	/ /	Número de archivo médico
Nombre(s) usados previamente		

Dirección	Ciudad	Estado	Código postal
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1. Liberen cualquier información psicológica o psiquiátrica de las siguientes fechas:
 _____ / _____ / _____ _____ / _____ / _____ _____ / _____ / _____ _____ / _____ / _____

2. Propósito por lo cual esta información será usada: A petición del individuo Transferencia de cuidado médico

Consulta médica: _____ / _____ / _____ hora: _____ Número de fax de la clínica: (_____) - _____

Otros tratamientos y cuidados en curso: _____

Otro (especifiqué): _____

3. Información será **revelada por**:

Organización: _____ Teléfono (_____) - _____

Atención: _____

Dirección	Ciudad	Estado	Código postal
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4. Información será **enviada a**:

Organización: _____ Teléfono: (_____) - _____

Atención: _____

Dirección	Ciudad	Estado	Código postal
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Yo entiendo que yo tengo el derecho a revocar esta autorización a cualquier momento, excepto cuando acciones ya han sido tomadas en base de esta autorización. Para revocar esta autorización, yo tengo que proporcionar un escrito al departamento de correspondencia de archivos médicos del Hospital de Children's Mercy o a la otra organización nombrada. A menos que esta autorización sea revocada, se vencerá una vez que la liberación sea completa.

Yo no necesito firmar una autorización específica para revelar información para tratamiento, pago, u operaciones para el cuidado de salud. Yo entiendo que autorizando la revelación de esta información es voluntario. Yo me puedo negar a firmar esta autorización. Yo no tengo que firmar esta forma para asegurar tratamiento. Yo entiendo que yo puedo inspeccionar o mandar que la información sea copiada para ser usada o revelada. Yo entiendo que si mi información de salud protegida es revelada a alguien quien no es requerido a cumplir con las protecciones de privacidad federales, tal información puede ser re-revelada y ya no seria considerada protegida. Si tengo preguntas sobre la revelación de mi información, yo puedo contactar al departamento de correspondencia de archivos médicos del Hospital de Children's Mercy al 816-234-3455.

Nombre impreso del paciente, padre, o guardián legal					
	/	/			
Firma del paciente, padre, o guardián legal	Fecha		Relación al paciente		
			() -		
Dirección	Ciudad	Estado	Código postal	Número de teléfono	

STAFF USE ONLY / SOLO PARA EL USO DEL PERSONAL:	<input type="checkbox"/> Information Released as Authorized:	
	_____ / _____ / _____ Signature	_____ / _____ / _____ Date

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