Release of Medical Information

This Release of Medical Information is to be used to confirm a clinical diagnosis of CCHS. Please complete this form, save a copy for your records, then submit either by uploading as instructed or by mail to the address on the next page. Once you have completed and submitted the release, both it and your registration form will be reviewed by the CCHS Network. We will contact your physician to confirm a clinical diagnosis of CCHS.

1. AUTHORIZATION

I authorize _____ (healthcare provider) to disclose the protected health information described below to CCHS Network.

2. EFFECTIVE PERIOD

This authorization for release of information pertaining to a clinical diagnosis of CCHS covers the *period of healthcare from*:

☐ _____ to _____.

OR

☐ all past, present, and future periods.

3. EXTENT OF AUTHORIZATION

☐ **I authorize the release of my CCHS health record to the CCHS Network.**

- This medical information may be used by the person I authorize to confirm a clinical diagnosis of CCHS.
- This authorization shall be in force and effective until three months after date of this signing, at which time this authorization expires.
- I understand that I have the right to revoke this authorization, in writing, at any time. I understand a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
- I understand the CCHS Network will destroy all documents concerning my CCHS diagnosis once clinical diagnosis has been verified.

(over)

Patient's Full Name (please print)	Patient's PHOX2B Mutation
Full Name of Person Submitting Release (please print)	Relationship to Patient
Signature of Patient or Person Submitting Release	Date

Physician's Name: _____

Physician's Contact Information: _____

_____

Physician's Phone number: _____

Physician's Email: _____

Hospital Affiliation: _____

Hospital Address: _____

_____

THANK YOU FOR COMPLETING THIS RELEASE OF LIABILITY.
Completed forms may also be submitted electronically or via mail:
CCHS Foundation
Release of Liability
71 Maple Street
Oneonta, NY 13820