Patient Name [redacted]

Address [redacted]

Medical Record # [redacted] Date of Birth 9/12/02

For the period of health care from (date) [redacted] to (date) [redacted]

1. I hereby authorize Shriners Hospitals for Children® [redacted] to disclose to

Name [redacted]

Street Address [redacted]

City, State & Zip Code [redacted]

2. Information to be disclosed

- [ ] Discharge summary
- [x] History & physical examination
- [ ] X-ray reports
- [ ] Billing Statements
- [x] Progress notes
- [ ] Laboratory tests
- [x] X-ray films/images
- [ ] Other
- [x] Operative reports
- [ ] Consultation reports
- [x] Photographs/slides

To publish a case series on the patient's surgery and post-operative course with photos and case report. This includes journals such as Journal of Pediatric Orthopaedics, JBJS Case Connector, Orthopaedic Journal of Sports Medicine, Arthroscopy, Sports Medicine and Arthroscopy

3. Reason for disclosure [redacted]

4. Separate signature required for release of information related to items below. Initial each line if required

- ___ Acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV)
- ___ Behavioral health services/psychiatric care/psychotherapy records
- ___ Alcohol and substance abuse diagnosis and treatment records
- ___ Pregnancy, contraceptives, and sexually transmitted diseases
- ___ Genetics testing

Signature for release of information in Item 4 [redacted]

5. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. **Unless otherwise revoked, this authorization will expire one year (12 months) from the original date for release of information to family members; six (6) months from the original date for all other releases.**

6. I have had the opportunity to ask questions regarding this Authorization and these questions have been answered fully.

7. I hereby release and agree to indemnify and hold harmless Shriners Hospitals for Children, it successors and assigns, and its agents and employees, from and against any claim or cause of action based on the release of requested health records and/or health information I previously authorized.

8. The recipient of this information might disclose it to other people. Shriners Hospitals for Children has no way to prevent this re-disclosure and cannot be held liable for such re-disclosures.

- [ ] I understand that I do not have to and have chosen not to sign this Authorization. My failure or refusal to sign will not affect my child's or my treatment or ability to receive treatment at Shriners Hospitals for Children.

[redacted] 1-22-21 9:54 AM/PM

Signature of patient (14 years or older) Date Time

Signature of the Parent/Guardian [redacted] Date Time

Print Name [redacted] Relationship to Patient Father

Signature of the Witness [redacted] Date 1-22 Time 9:54 AM/PM

Name (Print) [redacted]

SIGN HERE SIGN HERE

Signature of Parent/Legal Guardian Date Time AM/PM

Print Name Relationship to Patient

Signature of the Witness Date 1-22 Time 9:54 AM/PM

Name (Print)

uthorization for Disclosure of Health Information
hriners Hospitals for Children®

Patient Information Label

UDAS91A

.001a Rev. 05/2015

Patient Nam[redacted] Medical [redacted]

For the period(s) of health care from (date) 25-FEB-2014 to (date) 13-FEB-2020

1. I hereby authorize Shriners Hospitals for Children® SHREVEPORT. to disclose to:
   Name:_____
   Street Address:_____
   City, State & Zip Code:_____

2. Information to be disclosed:
   - ☐ Discharge summary
   - ☒ History & physical examination
   - ☐ X-ray reports
   - ☐ Billing Statements
   - ☒ Progress notes
   - ☐ Laboratory tests
   - ☒ X-ray films/images
   - ☐ Other
   - ☒ Operative reports
   - ☐ Consultation reports
   - ☒ Photographs/slides

3. Reason for disclosure: To publish a case series on the patient's surgery and post-operative course with photos and case report. This includes journals such as Journal of Pediatric Orthopaedics, JBJS Case Connector, Orthopaedic Journal of Sports Medicine, Arthroscopy, Sports Medicine and Rehab

4. Separate signature required for release of information related to items below. Initial each line if required.
   - ___ Acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV)
   - ___ Behavioral health services/psychiatric care/psychotherapy records
   - ___ Alcohol and substance abuse diagnosis and treatment records
   - ___ Pregnancy, contraceptives, and sexually transmitted diseases
   - ___ Genetics testing

   Signature for release of information in Item 4:_____

5. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. **Unless otherwise revoked, this authorization will expire one year (12 months) from the original date for release of information to family members; six (6) months from the original date for all other releases.**

6. I have had the opportunity to ask questions regarding this Authorization and these questions have been answered fully.

7. I hereby release and agree to indemnify and hold harmless Shriners Hospitals for Children, it successors and assigns, and its agents and employees, from and against any claim or cause of action based on the release of requested health records and/or health information I previously authorized.

8. The recipient of this information might disclose it to other people. Shriners Hospitals for Children has no way to prevent this re-disclosure and cannot be held liable for such re-disclosures.

☐ I understand that I do not have to and have chosen not to sign this Authorization. My failure or refusal to sign will not affect my child's or my treatment or ability to receive treatment at Shriners Hospitals for Children.

[redacted] AM/PM
Signa[redacted] Date Time

[redacted] AM/PM
Signature of the Parent/Legal Guardian Date Time

[redacted]
Print Name Relationship to Patient

[redacted] AM/PM
Signature of the Witness Date Time

Name (Print)

[redacted] AM/PM
Signature of the Witness Date Time

Name (Print)

Authorization for Disclosure of Health Information
Shriners Hospitals for Children®

Patient Information Label

* U D A 0 0 1 A *