Office for Genetics and
Children with Special Health Care Needs (OGCSHCN)
Baltimore, MD 21201

# Authorization to Obtain Medical Information

The Department of Health and Mental Hygiene provides newborn screening for sickle cell disease and related disorders as a service to newborn babies. The Office for Genetics and Children with Special Health Care Needs (OGCSHCN) follows up on all babies with abnormal test results to find out if they really do have the disorder and to be sure that they get the care they need. The OGCSHCN provides ongoing State sickle cell disease program services for children with sickle cell disease and related hemoglobin disorders. Services are provided at no cost to the families receiving the follow-up services.

The OGCSHCN is requesting the medical information that is required to follow-up abnormal newborn screening results. This information is needed to provide ongoing State sickle cell disease program services for the patient.

Patient Name _____
Social Security Number _____ D.O.B. _____
Mother's Maiden Name _____ Phone # _____
Other Contact Name _____ Phone # _____

I authorize the following provider _____
to release medical records, related to the diagnosis and treatment of sickle cell disease and other hemoglobin disorders, on the patient named above, to the Office for Genetics and Children with Special Health Care Needs (OGCSHCN). The records to be released are specified below:

- ☐ Lab work
- ☐ History and Physical Exam
- ☐ Medication Record
- ☐ Progress Notes
- ☐ Hematology Clinic Notes
- ☐ Radiology
- ☐ Pathology
- ☐ Discharge summary
- ☐ Immunization Records

I understand that by signing this consent form that I am giving the OGCSHCN permission make periodic requests for medical information about my child. The information will be used for follow-up purposes. This same consent will be used for each of these requests. I understand I have the right to revoke this authorization at any time by contacting the OGCSHCN. (The revocation will not apply to information that has already been released in response to this authorization.)

I understand that authorizing the disclosure of this health information is voluntary and I can refuse to sign this authorization. I understand I may inspect or receive copies of the information to be disclosed as provided in CFR 162.524. Medical Information released to OGCSHCN will not be re-disclosed and will continue to be protected under the federal confidentiality rules. If I have any questions about the disclosure of this health information, I can contact the OGCSHCN at 410-767-6730.

Parent Signature _____ Date _____
If not parent, state legal relationship _____

Please provide medical information to the following:

- ☐ Mail To: Office for Genetics and Children with Special Health Care Needs
  201 W. Preston St., Baltimore, MD 21201
- ☐ Fax To: (410) 333-5047 Attention: OGCSHCN