TICHFA AFRICA INC. — Medical Information Release Authorization

Tigawa International Children's Heart Foundation Africa | info@tichfa.org | www.tichfa.org

Patient and guardian

Child full legal name: _____

Date of birth: _____ Country: _____ Patient/reference ID (if assigned): _____

Parent/legal guardian name: _____

Relationship / legal authority: _____ Phone/email:

_____

Information to be disclosed

I authorize the following provider or organization to disclose information (name and address):

_____

To the following recipient(s), including name and secure contact/address:

_____

Information selected (check all applicable): ☐ Diagnosis and clinical notes ☐ Echocardiogram/ECG ☐ Imaging ☐ Lab results ☐ Medication/allergy list ☐ Surgical and discharge reports ☐ Referral letters ☐ Other: _____

Date range of records: _____ Exclusions or restrictions: _____

Purpose and method

Purpose: ☐ Specialist referral / treatment coordination ☐ Continuity of care ☐ Other: _____

Transmission method: ☐ Secure portal ☐ Encrypted provider-to-provider transfer ☐ Other secure method:

_____

This authorization does NOT permit public posting, fundraising use, or use of photographs. Those require separate consent.

Your choices and rights

Signing is voluntary. Refusal generally will not affect treatment or eligibility for services, except where a service specifically requires the requested disclosure to be performed.

You may revoke this authorization in writing at any time by contacting TICHFA at info@tichfa.org, except to the extent action has already been taken in reliance on it.

Information disclosed to a recipient not covered by HIPAA may be redisclosed and may no longer be protected by HIPAA. Other applicable privacy laws may still apply.

Expiration and signature

This authorization expires on (date): _____ OR upon this event: _____

Parent/legal guardian signature: _____

Date signed: _____ Printed name: _____

If signed by a personal representative, describe authority and attach verification as appropriate:

_____

TICHFA staff witness (optional): _____ Date: _____

Draft for legal and privacy review — not approved for clinical use.