**Health Information Management**
4650 Sunset Blvd, MS #46
Los Angeles, CA 90027
HIMrequest@chla.usc.edu
Phone: (323) 361-2387
Fax: (323) 361-1106
*Form 46-0845*

# AUTHORIZATION TO RELEASE HEALTH INFORMATION

*Completion of this form authorizes the use and/or disclosure (release) of individually identifiable health information, as set forth below, consistent with California and federal law concerning the privacy of such information.*

*Failure to provide all information requested may invalidate this authorization.*

| **Demographic Information** | |
|---|---|
| **Patient Name:** | |
| **Medical Record Number:** | **Date of Birth:** |
| **Parent/Guardian** (if under 18): | |
| **Address:** | |
| **Phone Number**: | **E-mail Address** (optional): |

| **Recipient Information** | |
|---|---|
| **Name:** | |
| **Organization** (if applicable): | |
| **Address:** | **Fax Number**: |
| **Phone Number**: | **E-mail Address** (optional): |

| **Form of Release** |
|---|
| *Check all that apply:*<br>☐ Paper copy<br>☐ Electronic copy (e.g. CD/DVD)<br>☐ Mailed to the *Recipient(s)* address above<br>☐ Picked up by *Recipient(s)* name above<br>☐ Faxed to provider:<br>Physician name/health care facility:<br>Fax number:<br>Phone number:<br>☐ Through oral communication with healthcare providers regarding treatment, care, or payment |

Children's Hospital LOS ANGELES
We Treat Kids Better

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## Purpose

- ☐ Personal (self or parent/guardian, if under 18)
- ☐ Continuation of care (e.g. changing physicians)
- ☐ Insurance
- ☐ Legal
- ☐ School
- ☐ Other (specify: )

## Treatment Date(s)

☐ Treatment date(s) from / / to / /

*(please be specific, including month, date, and year)*

☐ ALL treatment dates

## Information to be Released

- ☐ ENTIRE RECORD
- ☐ Summary Information (discharge summary, operative notes/procedure notes, radiology, pathology, laboratory, EKG, clinic visits, consults, etc.)
- ☐ Emergency Department (ED) Report/Record
- ☐ Immunization Records
- ☐ Clinic Notes (Ambulatory Progress Notes)
  Clinic name:
- ☐ History & Physical
- ☐ Discharge Summary/Instructions
- ☐ Radiology Reports
- ☐ Laboratory Reports
- ☐ Pathology Reports
- ☐ Operative Reports
- ☐ Billing Record
- ☐ Other (specify: )

My signature below also specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for: (please initial)

*Please note that the physician, licensed psychologist, social worker, or marriage/family therapist who was in charge of the patient's care may deny release of this information in limited circumstances.*

______ Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)

______ Sexually Transmitted Diseases/Infections (STDs/STIs)

______ Mental Health, Psychologic/Psychiatric Disorders

______ Drug or Alcohol Abuse or Treatment

______ Genetic Information and Testing

______ California Family Planning, Access, Care, and Treatment (FPACT) Services

*Please note that if a minor received family planning services, the release of these records requires authorization from the minor.*

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## Patient Rights

I understand that I may refuse to sign this Authorization, and that my refusal will not affect my ability to obtain care or treatment, except as permitted by law or the CHLA Notice of Privacy Practices. I understand that I may be charged for copies of the information requested above in accordance with state law.

I have a right to receive a copy of this Authorization, and may revoke this Authorization in writing at any time, signed by me or on my behalf. Revocation will not have any effect on any actions taken prior to receiving the revocation. Revocation will be effective when it has been received by Children's Hospital Los Angeles (CHLA) at the following address:

Children's Hospital Los Angeles
Health Information Management
4650 Sunset Blvd, MS #46
Los Angeles, CA 90027
Fax: (323) 361-2387

This Authorization becomes effective upon signing and will expire on ____ / ____ / ____. If no expiration date is indicated, this Authorization will automatically expire 180 days from the signature date.

Information disclosed pursuant to this Authorization may be re-disclosed by the recipient, and re-disclosure will not be protected by this Authorization. However, California law prohibits recipients of your/your child's health information from re-disclosing such information except with your written authorization or as specifically required or permitted by law.

## Signature

| Name: | Relationship to Patient* | Date |
|---|---|---|

** If the person signing the form is other than the parent, please attach documentation of authority.*