

CHILDRENS HOSPITAL LOS ANGELES
4650 Sunset Blvd. MS#46, Los Angeles, CA 90027
(323)361-2387 office (323)361-1106 fax

REQUEST FOR RELEASE OF HEALTH INFORMATION FROM CHLA

Completion of this document permits the release and/or use 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 Release.)

I hereby request Childrens Hospital Los Angeles to release my health information as follows:

- Physician Hospital Insurance School Nurse Attorney Self
- Other (please specify) _____
-

Patient Name: _____ Date of Birth: _____ Medical Record #: _____

Name, if different when care received: _____

Mother's Name: _____ Father's Name: _____

Address: _____ City/State/Zip: _____

Telephone: () _____ Fax: () _____

Person/Organization authorized to receive this information:

Organization/Person: _____

Address: _____ City/State/Zip: _____

Telephone: () _____ Fax: () _____

This release is limited to the following information:

Episodes of Care/Dates of Service requested: _____

- Pertinent Information (H&P, D/S, Cons., OP, Path, X-Ray, Lab, EKG)
- H&P Consultation Discharge Summary Operative Note(s) Progress Notes
- EKG X-Ray Report Pathology Report Lab ED Report

Clinic Notes/Dates of Treatment: _____

Other (please specify): _____

The purpose for which this information is to be used: _____

- This request shall become effective immediately and shall remain in effect until _____ (date).
- I have a right to receive a copy of this request. I want to receive a copy of this request:
 Yes No Initials: _____
- I may revoke this request at any time. My cancellation will be effective when it has been received in writing by Childrens Hospital Los Angeles. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address:
Childrens Hospital Los Angeles
Health Information Management
4650 Sunset Blvd. MS#46
Los Angeles, CA 90027
- If you have requested that your health information be sent to someone who is not legally required to keep it confidential it may be re-disclosed and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits recipients of your health information from re-disclosing your information except with your written authorization or as specifically required or permitted by law.
- Treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this request for release of information.

(Signature, if other than patient)

(Date)

(Time)

Relationship to patient: _____

Patient's Signature: _____

Witness: _____