

ATTN TO:
CHILDRENS HOSPITAL LOS ANGELES
Health Information Management
4650 Sunset Blvd. MS #46, Los Angeles, CA 90027

Office: (323) 361-2387 Fax: (323) 361-1106

REQUEST FOR RELEASE OF HEALTH INFORMATION TO 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 form)

TO: (Physician or Institution)

Office or Hospital Name: _____
Street Address: _____
City, State, Zip Code: _____
Telephone: _____ *Fax: _____

I hereby authorize and request the following Patient Health Information to be released to CHILDRENS HOSPITAL LOS ANGELES. Please direct your reply to the Health Information Management Department of Childrens Hospital.

REGARDING:

Patient Name: _____ Date of Birth: _____
Mother's Name: _____ Father's Name: _____
Address: _____ City/State/Zip: _____
Phone Number : _____ *Medical Record #: _____

This release is limited to the following information:

My child was treated in your: hospital clinic office (please check one)
*On or about: _____ (approximate dates of service).

Pertinent information (H&P, D/S, Cons., OP, Path, X-ray, Lab, EKG)

Progress/Clinic Notes Lab X-ray ER Record H&P

Discharge Summary Other (please specify) _____

[BAR CODE HERE]

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 initial _____.

I may revoke this request at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the above Physician or Institution . My cancellation will be effective when it has been received in writing by the above Physician or Institution.

If you have requested that your health information be sent to someone who is not legally required to keep it confidential it may be redisclosed and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits recipients of your health information from redisclosing 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.

Requested for: _____(Physician/Unit/Clinic)

Signature, if other than patient

Relationship to Patient

Date/Time

Patient's Signature: _____ (Patient is over 18 years old)

Witness: _____

* Please provide if information is available

[BAR CODE HERE]