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 81.1

☐ ***Request Completed***

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/Legal Representative (if under 18):			
Street Address:			
City:	**State:**	**Zip:**	**Country:**
Phone Number:		**Email Address** (optional):	

Recipient Information			
I authorize Children's Hospital Los Angeles (CHLA) to release health information to: ☐ Check if recipient is the individual named above **Name:**			
Organization (if applicable)**:**			
Street Address:			
City:	**State:**	**Zip:**	**Country:**
Phone Number:		**Fax Number:**	
Email Address (required if information is to be released via email)**:**			

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Form of Release

I would like the health information provided to Recipient in the following format (*please select one*):

☐ Paper Copy ☐ Electronic Copy ☐ Verbal (From Physician/Nurse only)

I would like the health information provided to Recipient via (*please select one*):

☐ Mail ☐ Pick up ☐ Fax ☐ Phone/Voicemail ☐ Email (*separate consent form required*)

Purpose

Reason I am requesting release of health information (check all that apply):

☐ Personal Use (self or parent/legal representative if under 18)
☐ Continuation of care (e.g. changing physicians)
☐ Insurance
☐ Legal
☐ School
☐ Other (please specify): _____

Limitations if any (explain):

Treatment Date(s)

Please release information relating to:

☐ Treatment Date(s) from _____/ _____/_____ to _____/ _____/_____
(*please specify month, date, and year*)

Please note: If you are unsure of treatment dates, then the most recent 2 years will be released.

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Information to be Released

Please check all that apply:

- ☐ Emergency Department (ED) Report/Record
- ☐ Immunization Records
- ☐ Billing Records
- ☐ History & Physical
- ☐ Radiology Reports
- ☐ Pathology Reports
- ☐ Discharge Summary/Instructions
- ☐ Clinic Notes (Ambulatory Progress Notes)
- ☐ Clinic name: _____
- ☐ Laboratory Reports
- ☐ Operative Reports
- ☐ Radiology Images
- ☐ **ALL** clinically relevant pertinent information for past 2 years.

My signature below also specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for: (*please initial on the lines provided, as appropriate*).

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)

_____ Psychotherapy notes and/or mental health treatment information (*release of these records requires completion of a separate form, 81.2*)

_____ Drug or alcohol abuse or treatment

_____ Genetic information and testing

California Family Planning, Access, Care, and Treatment (FPACT) Services (i*f a minor received FPACT services, 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 my refusal will not affect my/my child's health plan enrollment, benefit eligibility, or ability to obtain treatment, except as permitted by law or the CHLA Notice of Privacy Practices. I may inspect or obtain a copy of the health information that is the subject of this Authorization.

I have a right to receive a copy of this Authorization. I may revoke this Authorization in writing at any time, signed by me or on my behalf, except to the extent that others, including CHLA, have acted in reliance upon this Authorization. Revocation will be effective when it has been received by CHLA at the following address: Children's Hospital Los Angeles, Health Information Management, 4650 Sunset Blvd, MS #46, Los Angeles, CA 90027, Fax: (323) 361-1106.

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 could be redisclosed by the recipient. California law prohibits recipients of your/your child's health information from redisclosing such information except with your written authorization or as specifically required or permitted by law. However, in some cases, redisclosure is not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA).

Signature

Printed Name of Patient/Personal Representative	Relationship to Patient*
Signature of Patient/Personal Representative	/ / Date

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

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Email Consent Form

I have indicated in my Authorization to Release Health Information form that Children's Hospital Los Angeles (CHLA) should email my/my child's health information to the Recipient named in the form. Accordingly, I hereby expressly permit CHLA to release my/my child's health information to the Recipient named in my Authorization to Release Health Information form via email. I understand that this email will contain my/my child's Protected Health Information (PHI), and that the internet/email may not be secure or private. As a result, there is a risk that my/my child's health information and other sensitive or confidential information that may be contained in such emails may be misdirected, disclosed to, modified or intercepted by, unauthorized parties. CHLA will use reasonable means to protect the privacy of my/my child's health information, however, because of the risks outlined above, I understand and agree that CHLA cannot guarantee that health information sent via email will be confidential. I further agree to hold CHLA and any individuals associated with it harmless from any and all claims and liabilities arising from or related to my request to release my health information via email.

Signature

Printed Name of Patient/Personal Representative	Relationship to Patient*
Signature of Patient/Personal Representative	/ / Date