☐COMPLETED

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Fees may apply to certain requests. Failure to provide all information requested may invalidate this form.

Medical Record Number (if known):______________________________

Patient Name:______________________________________

Patient's Date of Birth:______________________________________

Parent/Legal Representative (if under 18):______________________

Address:____

City:_______________________________State:______________

Zip Code:______________ Country: ______________________

Phone: (   )______________ Email:________________________

☐ Check here if the same as above.

I authorize CHLA to release health information as follows:

Recipient Name &/or Organization:____

Address: ___________________________ City: __________________State: ______ Zip Code:___________

Country: __________________ Phone # (   ) __________________ Fax # (   ) ___________________

Email: ____

This disclosure can be used for the following purpose(s): ☐ Personal Use ☐ Continuation of care ☐Insurance ☐Legal ☐School ☐Other:_________________ ☐Limitations ________________

Check ONLY one of the following options to identify the health information to be released.

☐**Option 1:** Last 2 years of all clinically relevant pertinent information

☐**Option 2:** Records as specified. You must complete both Step 1 and Step 2 below:

Step 1. Enter date range or date(s) of the records to be released:___________________________

Step 2. Select types of records to be released:

☐ Emergency Department ☐ History and Physical ☐ Immunization ☐ Lab Results

☐ Discharge Summary ☐ Clinic Notes ☐ Radiology Reports

☐ Radiology Images ☐ Pathology Reports ☐ Operative Reports

Check the boxes below if you want this release to include the following sensitive information, otherwise this information will be excluded.

If the patient is 12 and over, their signature is required for the following sensitive information:

☐Genetic Records ☐STDs/STIs, HIV, AIDS ☐ Addiction Medicine Treatment Record ☐HIV Test Results ☐Mental Health Treatment Records

Patient Signature:____

For the patient at any age, their signature is required for the following sensitive information:

☐Prevention or treatment of pregnancy

Patient Signature:____

Note: Release of this information may be denied in limited circumstances.

Format: ☐Electronic ☐Paper ☐Verbal (from Physician or Nurse Only)

Delivery Preference: ☐E-Mail ☐Mail ☐Phone/Voicemail ☐Fax ☐USB Drive ☐CD/DVD-Rom ☐Other __________________________

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

Health Information Management
4650 Sunset Blvd. MS #46 Los Angeles, CA 90027
ROI@chla.usc.edu
Phone: 323-361-2387 Fax: 323-361-1106

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.

Revocation. 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 Health Information Management Services, 4650 Sunset Blvd. MS#46, Los Angeles, CA 90027, Fax 323-361-1106.

Redisclosure. 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 privacy law.

Authorization to E-mail. I have indicated in my Authorization to Release Health Information 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. **Initial here ______ to agree to CHLA transmitting the requested records via e-mail.**

Signature

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

*If the person signing this Authorization is other than the patient/ parent, attach documentation of authority.