



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:
Phone Number:	Email Address (optional):	

Recipient Information		
I authorize Children's Hospital Los Angeles (CHLA) to release health information to:		
<input type="checkbox"/> Check if recipient is the individual named above		
Name:		
Organization (if applicable):		
Street Address:		
City:	State:	Zip:
Phone Number:	Fax Number:	
Email Address (optional):		

Form of Release		
I would like the health information provided to Recipient in the following format (<i>please select one</i>):		
<input type="checkbox"/> Paper copy	<input type="checkbox"/> Electronic copy (CD/DVD)	
I would like the health information provided to Recipient via (<i>please select one</i>):		
<input type="checkbox"/> Mail	<input type="checkbox"/> Pick up	<input type="checkbox"/> Fax



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- 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, 46-0845B*)
- Drug or alcohol abuse or treatment
- Genetic information and testing
- California Family Planning, Access, Care, and Treatment (FPACT) Services (*if a minor received FPACT services, release of these records requires authorization from the minor*).

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

 Signature of Patient/Personal Representative

 Relationship to Patient *

 Date

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