CHOC Children's

Authorization for Use or Disclosure of Health Information

Completion of this document authorizes the disclosure 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 AUTHORIZATION.

Name of Patient: _____ Date of Birth: ____ / ____ / _____

INFORMATION TO BE RELEASED FROM: *(MUST BE FILLED IN **COMPLETELY**)*

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

INFORMATION TO BE RELEASED TO:

Children's Hospital of Orange County
1201 W. La Veta Avenue
Orange, CA 92868
Phone #: (_____) _____ - _____ Fax #: (_____) _____ - _____

Please release the following information: check requested items

- ❑ Discharge Summary
- ❑ History & Physical
- ❑ Operative Report
- ❑ Consultations
- ❑ Radiology Reports
- ❑ Radiology Images
- ❑ Laboratory Reports
- ❑ Immunization Records
- ❑ Nurses' Notes
- ❑ Ambulatory Clinic
- ❑ Specialty Clinic _____
- ❑ Emergency Room Report
- ❑ Pertinent Information (all reports, radiology, labs, etc.)
- ❑ Other: _____

Dates of Treatment: _____

Purpose of requested use of disclosure:

- ❑ Patient/Parent Request
- ❑ Continuing Care
- ❑ Legal
- ❑ Insurance
- ❑ Other _____

This authorization expires:

- ❑ From the date of this authorization until___/___/___(date must be specified)
- ❑ Until the following event occurs (must be specific): _____

CONTINUED ON REVERSE SIDE

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- Neither treatment, payment, enrollment, or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.
- I may revoke this authorization at any time. My revocation must be in writing and forwarded to the CHOC Privacy Official, Health Information Management Department.
- My revocation will be effective upon receipt but will not be effective if CHOC has already processed original request for release of health information.
- I understand that I may inspect or obtain copies, for a fee, of the health information that is being released.
- I understand that once the above information is released the recipient may redisclose it and the information may not be protected by federal privacy laws or regulations. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required by law.

I have a right to receive a copy of this authorization.
Copy Requested ❑ Yes ❑ No Initial _____ Date _____ / _____ / _____

DISCLOSURES REQUIRING SPECIAL CONSENT:
My signature below also specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for (please initial):

_____ HIV/AIDS Virus
_____ Sexually Transmitted Diseases
_____ Mental Health/Psychiatric Disorders
_____ Drug, Alcohol Abuse/Treatment

_____
Print Name of Patient/Parent/Legal Representative

_____ _____
Relationship to Patient Phone Number

_____ _____ / _____ / _____
Signature of Patient/Parent/Legal Representative Date

OFFICE USE ONLY:
ROI PROCCESSED BY (PRINTED NAME): _____ DATE: _____ / _____ / _____

MRN: _____

998456 (12/2018)