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:

Children's Hospital of Orange County
1201 W. La Veta Avenue, Orange, CA 92868
Phone # (714) 509 – 4368 Fax # (714) 509 – 8388

INFORMATION TO BE PROVIDED TO: ***(MUST BE FILLED IN COMPLETELY)***

Name: ____

Address: ____

City: ____ State: _______ Zip: _____________

Phone: ________________________________ Fax: ________________________________

Please Note: A fee may be charged for providing records. You will be notified in advance should any apply.

I would like: ☐ Paper ☐ CD ☐ FAX (list number above)
Deliver Method: ☐ Mail ☐ Hold for Pick Up
☐ Electronic via Email (complete information below)

Email Address: ____

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: ____

CONTINUED ON REVERSE SIDE

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CHOC Children's

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

PATIENT ID

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 CHOC Children's fulfills this request
☐ Until the following even occurs (must be specific): __________________________

- 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 _____Mental Health/Psychiatric Disorders
_____Sexually Transmitted Diseases _____Drug, Alcohol Abuse/Treatment

____ ____/____/_____
Signature of Patient/Parent/Legal Guardian Date

____ __________________________
Printed Name of Patient/Parent/Legal Guardian Relationship to Patient

____
Phone Number

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OFFICE USE ONLY:

ROI PROCESSED BY (PRINTED NAME): ______________________________

DATE: ____/____/______ **MRN:** ____________________