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:
CHOC Children's Garden Grove Clinic
10602 Chapman Ave suite 100 Garden Grove,CA 92840

INFORMATION TO BE PROVIDED TO:
Name _____
Address _____
City _____ State _____ ZIP _____ Phone _____

❑ **Check this box if you would like to pick up the copies of the records (fees apply)**

Reason you are requesting release of health information (Please check **ONE**):
❑ Personal Use – inspection/access/copies ($0.25 per page plus tax applies; postage may also apply unless copies are to be picked up)
❑ Sharing with other health care providers for treatment purposes (this service is performed free as long as the records are to be sent directly to the provider)
❑ Other (please describe):_____

Please release the following information: check requested items

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

Dates of Treatment: _____

CONTINUED ON REVERSE SIDE

This authorization expires on the following date or event: _____
(MUST HAVE DATE ENTERED)

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 I may receive a copy of this completed authorization form if I choose.

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.

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

_____ _____
Signature of Patient/Parent/Legal Representative Date

_____ _____
Relationship to Patient Phone Number

2001 (REV 4/04)
2005 (REV 5/05)
2006 (REV 12/06)
2007 (REV 2/07)
2007 (REV 05/07)