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: ☐ 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 (*please select one*): ☐ Paper copy ☐ Electronic copy (CD/DVD) I would like the health information provided to Recipient via (*please select one*): ☐ Mail ☐ Pick up ☐ Fax

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Purpose

Reason I am requesting release of health information (check all that apply):

- ☐ Personal Use (self or parent/legal representative if under 18)
- ☐ Continuation of care (e.g. changing physicians)
- ☐ Insurance
- ☐ Legal
- ☐ School
- ☐ Other (please specify): _____

Limitations if any (explain):

Treatment Date(s)

Please release information relating to:

☐ Treatment Date(s) from / / to / /
(*please specify month, date, and year*)

☐ ALL Treatment Dates

Information to be Released

Please check all that apply:

- ☐ ENTIRE MEDICAL RECORD
- ☐ Pertinent Summary Information (i.e., procedure notes, pathology, laboratory, EKG, clinic visits, consults, etc.)
- ☐ Emergency Department (ED) Report/Record
- ☐ Immunization Records
- ☐ Billing Records
- ☐ History & Physical
- ☐ Radiology Reports
- ☐ Pathology Reports
- ☐ Other (Specify): _____
- ☐ Clinic Notes (Ambulatory Progress Notes)
- ☐ Clinic name: _____
- ☐ Discharge Summary/Instructions
- ☐ Laboratory Reports
- ☐ Operative Reports
- ☐ Radiology Images

My signature below also specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for: (*please initial on the lines provided, as appropriate*)

Please note that the physician, licensed psychologist, social worker, or marriage/family therapist who was in charge of the patient's care may deny release of this information in limited circumstances.

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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 (i*f 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*.