

COMPLETED

CHILDRENS HOSPITAL LOS ANGELES
4650 Sunset Blvd #46, Los Angeles, CA 90037
Office: (323) 361-2387 Fax: 323-361-1106

REQUEST FOR RELEASE OF HEALTH INFORMATION

Completion of this document permits the release 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 Release.)

I hereby request Childrens Hospital Los Angeles to release my health information as follows:

- Physician
 Hospital
 Insurance
 School Nurse
 Attorney
 Self
 Other (please specify) _____

Patient Name: _____ Date of Birth: _____ Med Rec # _____

Name, if different when care received: _____

Mother's Maiden Name: _____ Father's Name: _____

Address: _____ City/State/Zip: _____

Telephone () _____ Fax: () _____

Person/Organization authorized to receive this information:

Organization/Person: _____

Address: _____ City/State/Zip: _____

Telephone () _____ Fax: () _____

This release is limited to the following information:

Episodes of Care/ Dates of Service requested: _____

- Pertinent information (H&P, D/S, Cons., OP, Path, X-ray, Lab, EKG)
 H&P
 Consultation
 Discharge Summary
 Operative Note(s)
 Progress Notes
 EKG
 X-Ray Report
 Pathology Report
 Lab
 ED Report
 Clinic Notes / dates of treatment: _____
 Other (please specify): _____

The purpose for which this information is to be used: _____

- This request shall become effective immediately and shall remain in effect until _____ (date).
- I have a right to receive a copy of this request. I want to receive a copy of this request- yes no/initial _____
- I may revoke this request at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address: **Childrens Hospital Los Angeles, Health Information Management, 4650 Sunset Blvd.—MS #46, Los Angeles, CA 90027.** My cancellation will be effective when it has been received in writing by Childrens Hospital Los Angeles.
- If you have requested that your health information be sent to someone who is not legally required to keep it confidential it may be redisclosed and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits recipients of your health information from redisclosing your information except with your written authorization or as specifically required or permitted by law.
- Treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this request for release of information.

Signature, if other than patient _____

Date _____

Time _____ am / pm

Relationship to patient: _____

Patient's Signature: _____

