CHILDREN'S HOSPITAL
& RESEARCH CENTER OAKLAND

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

747 52nd Street, Oakland, California 94609
Telephone: 510-428-3000

Patient Name: _____
Last First Initial

DATE OF BIRTH: ____/____/____ MR/UNIT#_____

I AUTHORIZE: ☐ Children's Hospital & Research Center Oakland

☐ Other Healthcare Provider_____

TO RELEASE/DISCLOSE HEALTH INFORMATION TO (Person or place records should be sent):

_____ _____
Name or Person or Organization Receiving Information Mailing Address City State Zip Code

☐Check this box to authorize exchange between the persons/organizations listed above.

DATES OF TREATMENT ☐ **From**_____ **to** _____ ☐ **All dates of service**

INFORMATION REQUESTED (CHECK ALL THAT APPLY)

☐Pertinent Summary ☐Emergency Record ☐Clinic Records ☐Immunizations

☐ Other (List)_____

PURPOSE OF RELEASE ☐Medical Care ☐Insurance/legal claim ☐Patient/Personal

☐Other, Please explain_____

This section must be completed on all requests. Initial the appropriate boxes.

I understand that my medical record may also include information on diagnosis and/or treatment related to psychiatric (mental health conditions) and/or HIV status.

_____I authorize _____ I do not authorize psychiatric information to be released.

_____I authorize _____ I do not authorize HIV status information to be released.

Limitations if any:_____

This authorization will expire one (1) year from the date signed or on_____ unless otherwise revoked. I understand this authorization may be revoked in writing at any time, except to the extent that Children's has already disclosed the information. I must submit my revocation to Children's Hospital & Research Center Oakland, HIM Dept., 747 52nd St., Oakland, CA 94609.

I understand:

- I may refuse to sign this authorization. Treatment, may not be withheld or conditioned on obtaining this authorization.
- If disclosure of this health information is to someone who is not legally required to keep it confidential, it may be redisclosed and may be no longer protected.
- I have a right to receive a copy of this authorization.

_____ _____ _____
Signature Date Area Code and Phone Number

If signed by other than patient, indicate legal relationship:_____

Revised: 10/01/08