Children's Hospital of Orange County
455 South Main Street
Orange, Ca. 92868

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**.

Printed Name of Patient_____Date of Birth_____

SEND INFORMATION TO: *(Please be specific*)
Provider Name/Organization_____
Address_____
Phone_____Fax_____

INFORMATION TO BE RELEASED FROM: (*Please be specific)*
Provider Name/Organization_____
Address_____
Phone_____Fax_____

Reason you are requesting release of health information:

- ☐ My personal records –inspection/access/copies (fee involved)
- ☐ Sharing with other health care providers for treatment purposes
- ☐ Other (please describe):_____

Please release the following information: check requested items

☐ Discharge Summary	☐ Immunization Records
☐ History & Physical	☐ Ambulatory Clinic
☐ Operative Report	☐ Specialty Clinic (*specify clinic)*
☐ Consultations	_____
☐ Radiology Reports	☐ Billing Records
☐ Laboratory Reports	☐ Other
☐ Emergency Room Report	_____

Dates of Treatment: _____

This authorization expires on the following date_____

CONTINUED ON REVERSE SIDE

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.

DISCLOSURES REQUIRING SPECIAL CONSENT:
My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for:

- ☐ 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 _____

Records Received by: _____ Date _____

I have a right to receive a copy of this authorization

For Healthcare Organization Use Only

Medical Record Number:_____
Date request received:_____ Date processed_____
Associate processing request_____
Copy of authorization provided to patient ☐ Yes ☐ Not Requested

2001 (REV 4/04)
2005 (REV 5/05)