Stanford Children's Health

PLEASE DROP OFF OR SEND THIS COMPLETED FORM TO:

Stanford Children's Health **HIMS Department**

Mailing Address: 4700 Bohannon Drive, 2nd Floor, Menlo Park CA 94025, MC 5900

Via Email: HIMS-ROI@stanfordchildrens.org **Phone:** (650) 497-8334

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

When you complete and sign this form, health information about you will be released as you describe in the form. Please read each section carefully and complete the required sections before signing. We encourage you to request a copy of your records and review them before authorizing the release of the records to someone other than you. Please clearly and legibly print all information when completing this form and sign on the last page.

FACILITY/HEALTHCARE PROVIDER YOU WOULD LIKE YOUR RECORDS RELEASED FROM

I hereby authorize:

❑ **PCHA, 2915 Telegraph Ave. Ste 200, Berkeley, CA 94705**

❑ (Other Healthcare Provider) _____

SECTION A: PATIENT INFORMATION

Please print the name of the patient whose records are being requested for release.

*Patient's name: Last:*_____*First:*_____*M:*_____

*Date of birth:*_____ *Phone number:*_____*Medical Record number:*_____

Indicate if patient is part of multiple births: ❑Twin ❑Triplets ❑Other:_____

SECTION B: <u>WHAT TYPE OF MEDICAL RECORDS?</u>

Please describe the specific health information you would like released by completing the appropriate information below. **Certain specific health information requires a separate indication from you in order for us to release that information, such as HIV test results, hereditary disorder test results, family planning services and certain mental health information. If you would like this information released, you will need to indicate separately below.**

General Health Information Release (Please note: if you do not specifically request certain specific information described above and there is information in your record as described above, the information will not be included in the release .)

❑_____ Check here **and initial** next the box if you would like information related to specific dates of service released and not the entire medical record. Indicate dates of service:_____

❑_____ Check here **and initial** next to the box if you would like to further describe the specific health information that you would like released, and please provide a description:_____

_____

_____

❑_____ Check here **and initial** next to the box if you would like your entire medical record released.

❑_____ Check here **and initial** next to the box if you had HIV tests performed and would like the HIV test results released.

❑_____ Check here **and initial** next to the box if you authorize the following physician(s) who are not involved in your treatment to access your electronic medical record and you are not requesting the release of your printed medical record:

_____

_____

_____

SECTION C: WHO/WHERE SHOULD RECORDS BE RELEASED TO?

Please indicate the facility or person whom you authorize to receive the health information indicated on this form. Please note that if you wish to impose restriction on the recipient's use of the health information, you must contact the recipient directly.

*Name of person or facility to receive the health information:*_____

*Address:*_____

*Phone:*_____

SECTION D: REASON FOR YOUR REQUEST

Please indicate the reasons you would like your health information released.

❑ Check here if you are the patient or legal representative and you do not want to provide the reason.

❑ Check here if the release is not to the patient or legal representative and provide the reason for the release here_____

SECTION E: HOW WOULD YOU LIKE TO RECEIVE OR HAVE YOUR RECORDS SENT?

Please indicate how you would like this information sent to the recipient.

❑ Check here if you would like health information mailed to the recipient address in section C.

❑ Check here if you will pick up the health information at the hospital Health Information Management Services Department (HIMS). Please indicate how you would like to receive health information you are requesting: ❑ Paper Copy ❑ CD Copy
Please note: *Copies of requested health information will be billed according to current fee schedule.*

❑ Check here if you are not requesting a copy of your health information but would like to inspect your records in the HIMS Department. Someone from the HIMS Department will contact you to make these arrangements.

❑ Check here if this is an emergency situation (i.e. patient currently being treated at this time in medical facility) and you would like the health information faxed to the facility. Provide the fax number here_____. Faxing of medical records is available only

in emergency situations.

SECTION F: EXPIRATION OF THIS AUTHORIZATION

This authorization becomes effective upon signing and will expire on (date)_____

Please note that if no date is indicated, this authorization will expire one (1) year from the signature date.

SECTION G: YOUR PRIVACY RIGHTS

- You may refuse to sign this authorization. Your refusal will not affect your ability to obtain treatment, insurance payment or eligibility for benefits.
- You have the right to withdraw or revoke this authorization in writing at any time, except to the extent that Packard Children's Health Alliance has already released the health information. To withdraw or revoke your authorization, please submit your request in writing to PCHA, Health Information Management Services (HIMS) Department, **4700 Bohannon Drive, 2nd Floor, Mail Code 5900, Menlo Park, CA 94025.**
- PCHA may deny your request to inspect and /or receive a copy of your health information under certain circumstances authorized by law. You will be notified of any such denial and of how you may appeal such denial.
- You have the right to receive a copy of this authorization.

SECTION H: CAUTIONS BEFORE SIGNING

Your health information that will be released as a result of you signing this authorization could be re-disclosed by the recipient. If this occurs, your re-disclosed health information may no longer be protected by state or federal privacy law.

We encourage you to request a copy of your records and review them before authorizing the release of the records to someone other than you.

The release of this information may involve certain risks, such as re-disclosure by the recipient, loss or compromise of insurance benefits or employment status.

If you have questions about this authorization form or the release of your health information, please contact the PCHA HIMS Department at **(650) 497-8334.**

SECTION I: SIGNATURE AND DATE

Please sign and date this form to authorize Packard Children's Health Alliance to release your information as stated on this form.

_____ _____

SIGNATURE (Patient, Parent or Properly Designated Representative) Date

_____ _____

PRINT NAME OF SIGNATOR RELATIONSHIP to Patient

*Address of patient or legal representative signing this form (please print):*_____

_____

*Phone number of patient of legal representative signing this form (please print):*_____

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Via Email: HIMS-ROI@stanfordchildrens.org

FOR OFFICE USE ONLY:

- ❑ Processed by (Print Name): _____ Date Processed: _____
  Department: _____ Phone#/Extension:_____
- ❑ Sent to HIMS for processing Date sent:_____

A COPY OF THIS AUTHORIZATION FORM MUST BE GIVEN TO THE REQUESTOR