PLEASE DROP OFF OR SEND THIS COMPLETED FORM TO:

Stanford Children's Health LPSR Pediatrics
1133 E. Stanley Blvd., Suite 103
Livermore, CA 94550
Phone Number: (925) 455-5050
Fax: (925) 455-5084

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 **Lucille Salter Packard Children's Hospital**
STANFORD UNIVERSITY MEDICAL CETER • 725 Welch Road, Palo Alto, CA 94304

when completing this form and sign on the last page.

FACILITY/HEALTHCARE PROVIDER YOU WOULD LIKE YOUR RECORDS RELEASED FROM

I hereby authorize:

❑ **Stanford Children's Health, LPSR, 1133 E. Stanley Blvd., Ste. 103, Livermore, CA 94550**

❑ (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 on the following pages. 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. You must check the box and initial next to the box to authorize the release of the information described after the box. Certain notes requires a review/approval from the author such as psychotherapy notes, prior to release.

B.1: General Health Information Release

(Please note: if you do not check any of the boxes in Sections B.2, B.3, B.4, B.5 or B.6 below and there is information in your record as described in those sections, the information described in those sections will not be included in the release if you simply check the boxes in B.1).

❑ _____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:_____

Please further describe the 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 would like records for other PCHA clinics. Please indicate name/address of PCHA Clinic

_____

❑ _____Check here **and initial** next to the box if you would like records for visits at **other** Stanford Children's Health clinic locations or Lucile Packard Children's Hospital. Those requests are processed by the Stanford Children's Health HIMS department. We will forward this request to them for processing. Please call (650) 497-8334 for further information.

B.2: Mental Health Information

☐ _____Check here **and initial** next to the box if you had any behavioral health and or outpatient psychiatric services provided and you would like these records released. 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 your information in limited circumstances. You will be notified of any such decision.

IMPORTANT NOTE ABOUT MENTAL HEALTH INFORMATION: If you request mental health records to be sent out to a continued care provider, those records will be sent out without prior review from the provider. We encourage you to request a copy of your records and review them before authorizing the release of the records.

B.3: HIV Lab Test Results

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

B.4: Hereditary Disorder Test Results

☐ _____Check here **and initial** next to the box if you had Hereditary Disorder tests performed and you would like the Hereditary Disorder test results released. Hereditary Tests include antenatal, neonatal, childhood and adult hereditary disorder screening records and/or related genetic counseling services that were provided in the Genetic counseling Department (all test results and records and/or related genetic counseling services that were provided in the Genetic counseling Department (all test results and records generated as part of the hereditary Disorders Program). The release of this information may involve the following risks; re-disclosure by the recipient of Hereditary disorder test results, loss or compromise of insurance benefits, or employment status. The release of this information may involve the following benefits: predetermination of genetic conditions, coordination of care, treatment options. You should consult your physician concerning the risk and benefits of specific tests.

B.5: Family Planning Services

☐ _____Check here **and initial** next to the box if you had California Family Planning, Access, Care and Treatment (FPACT) services and would like this information released. FPACT services may include clinical services, drug and supply services or laboratory services provided at the Gynecology Clinic (GYN) or the Reproductive Endocrinology and Infertility Clinic (REI). If a minor has received family planning services, the release of these records requires authorization from the minor.

B.6: LPCH Non-Treating Physician Access To Electronic Medical Record

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

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

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: <u>REASON FOR YOUR REQUEST</u>

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.
  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 clinic. Someone from LPSR 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 and faxed only to health care facilities.

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 Lucile Packard Children's Hospital has already released the health information. To withdraw or revoke your authorization, please submit your request in writing to Stanford Children's Health, LPSR Pediatrics, 1133 E. Stanley Blvd., Ste. 103, Livermore, CA 94550
- LPSR 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 LPSR at (925) 455-5050

SECTION I: SIGNATURE AND DATE

Please sign and date this form to authorize Lucile Packard Children's Hospital 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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Phone: (925) 455-5050

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