Rady Children's Hospital San Diego

Rady Children's Hospital – San Diego
3020 Children's Way
San Diego, CA. 92123

DTF525

PATIENT INFORMATION

Name: _____
MR#: _____ Finance: _____
DOB: _____
MD: _____

Authorization for Observation of a Clinical, Surgical or Invasive Procedure

EXPLANATION: This form authorizes the use or disclosure of protected health information in the clinical, surgical/invasive procedure observation process. Your approval of the observation process is voluntary, and Children's Hospital & Health Center cannot condition services on whether or not you sign this authorization.

It is the policy of Children's Hospital San Diego to ensure the confidentiality of protected health information in compliance with all state and federal laws. Your child's surgeon, physician, and clinical leadership has requested that the following visitors observe your child's procedure/clinical care: _____

_____

The purpose of the observation:

- ❒ Teaching
- ❒ Research
- ❒ Clinical Outreach
- ❒ Other (please describe):_____

_____

YOUR RIGHT :I, the undersigned, acknowledge that I have been informed regarding the presence of visitors before, during and after my child's surgery or visit. I understand that the visitor will be able to observe, discuss and access clinical information concerning my child. I hereby give my consent to have my child observed by other professional visitors for the purpose of teaching, research and/or advancing clinical care.

DURATION: I understand this authorization may be revoked in writing at any time, according to the instructions in the Children's Hospital & Health Center Notice of Privacy Practices, except to the extent that action had been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire six months from the date of this authorization.

RESTRICTIONS: I understand that Children's Hospital & Health Center may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. I hereby release Children's from any/all legal liability that may arise from the release of this information to the party named above.

ADDITIONAL COPY: I further understand that I have a right to receive a copy of this authorization upon my request. (Civil Code S.56.11)

APPROVAL

_____ _____ _____
Signature Date Witness

_____ _____
Relationship to Patient Area Code & Phone Number