Rady Children's Hospital San Diego
3020 Children's Way
San Diego, California 92123-4282

DT79600

PLACE PATIENT
ID LABEL INSIDE BOX

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes Rady Children's Hospital-San Diego to disclose health information about you/your child as indicated below. Failure to provide all information requested may invalidate this authorization.

Patient Information:	Patient Name:	
	Address/City/State/Zip:	
	Date of Birth:	___/___/___
	Medical Record Number (if known):	
Record Holder: *Who has the information you want released?*	❑ Rady Children's Hospital-San Diego ❑ Other: ______________________________	
Release Records to: *Where do you want records sent? Who do you want to receive the records?*	Name of Hospital/Clinic/Person:	
	Street Address/City/State/Zip:	
	Phone:	
	Fax (Urgent Patient Care Only):	
Purpose:	❑ Continuing Care ❑ Legal Matter ❑ Personal Copy ❑ School ❑ Other (*please specify*): ______________________________	
Delivery Method: *How would you like to receive the records? Choose a delivery method from the list provided.*	(Please Choose One): ❑ Through MyChart ❑ Printed and Mailed to Me* ❑ Printed and Picked up ❑ Mailed to me on USB/Thumb Drive ❑ Encrypted email to (*email address*): ______________________ * Medical records greater than fifty (50) pages are provided electronically on an encrypted USB thumb drive (requestor will receive advance notice re: size of record).	

Health Information to be Released: *What do you want sent or released?*	❑ Clinic or Office Visit records dated from __________ to ____________ ❑ Emergency Department records from ___________ to ______________ ❑ Hospital records dated from ____________ to ____________ Specific records or reports including: ❑ Discharge Summary ❑ History/Physical Examination ❑ Consultation Reports ❑ Progress Notes ❑ Laboratory Tests ❑ Radiology Imaging Reports ❑ Photographs ❑ Genetic Testing ❑ Operative Report ❑ Other:___________________________________ ____ ❑ Radiology Images (specify type): ❑ X-ray ❑ MRI ❑ CT ❑ EEG ❑ Ultrasound ❑Echo ❑ Other:___________________________________ ____ Note: Radiology images are mailed on a CD. If you prefer to receive the images electronically, please provide an email address to receive an encrypted email communication: ____
Records Requiring Special Authorization:	I specifically authorize release of the following records: (*check appropriate boxes*): ❑ Mental Health Treatment Information ❑ HIV Test Results ❑ Alcohol/Drug Treatment ❑ Genetic Test Results ❑ Sexually Transmitted Diseases/Infections (STDs/STIs) ❑ Adolescent/Reproductive Health RESTRICTIONS: * Under California Law, 12–17 year-old patients have the right to consent to certain treatment or services. In those cases, the patient must sign this form to authorize the release of those requested records. In some situations, a provider (e.g., physician, licensed psychologist, social worker, or therapist in charge of the patient's care) may withhold records (e.g., if they have determined the release of those records could result in harm to the patient or a third party, or if release of records could damage the patient/provider relationship). In those cases, the requestor will be informed of the reason for the denial.

Authorization and Revocation:	I understand this authorization is voluntary and that refusal to sign will not affect my ability to obtain treatment from Rady Children's. I understand this authorization may be revoked in writing at any time, according to the instructions in the Rady Children's Joint Notice of Privacy Practices, except to the extent that action had already been taken in reliance on this authorization.
Notice:	Rady Children's and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws. I understand that I have a right to receive a copy of this authorization upon my request.
Expiration:	Unless otherwise revoked, this authorization will expire one (1) year from the date this authorization is signed.

SIGNATURE:

Please sign and date this form to authorize Rady Children's to release the information as stated on this form:

______________________________	____________________	________________
Signature of Parent/Legal Guardian or Patient (if over 18, ID required)	Printed Name	Phone Number
______________________________	____________________	
Relationship to Patient *(if signed by person other than patient)*	Date	
______________________________	____________________	________________
* Adolescent Patient Signature if Requesting Records Requiring Special Authorization	Date	Phone Number