Rady Children's Hospital San Diego

DTF1397

PLACE PATIENT ID LABEL INSIDE BOX

Authorization to Schedule/Reschedule/Cancel/Confirm Visits For Patients 18 years old or Over

THIS AUTHORIZATION FORM IS NOT TO BE USED FOR RELEASE OF MEDICAL RECORDS/DISCLOSURE OF HEALTH INFORMATION (E.G., TREATMENT OR DIAGNOSIS INFORMATION). A SEPARATE FORM IS AVAILABLE THROUGH HEALTH INFORMATION MANAGEMENT FOR THAT PURPOSE.

EXPLANATION: This form authorizes the use or disclosure of visit information in the manner described below and is voluntary. Rady Children's Hospital-San Diego (RCHSD) cannot condition services on whether or not you sign this authorization. Please be aware that once your visit information has been released, RCHSD will no longer be able to protect that information, and the recipients of your information may not be legally required to protect your information.

AUTHORIZATION: I hereby authorize RCHSD its staff and its providers to furnish information pertaining to my visits at RCHSD. "Visits" refers to appointments I have scheduled with outpatient departments and clinics, as well as planned surgeries and admissions to the hospital. The individual named below has my authorization to schedule, reschedule, cancel, confirm any and all visits that I may have at the hospital or its specialty clinics.

Name and address of individual who has this authority: _____

Dates of Service: Any and all dates of service

Location of service: ☐ Physician Office ☐ Inpatient ☐ Outpatient ☐ Emergency ☐ Other

This authorization is limited to information related to visits only. I understand a separate signed Authorization for Use or Disclosure of Health Information will be required if I wish to share medical records and other health information with the individual named above. I will contact Health Information Management at (858) 966-5904 to obtain information on requesting medical records.

USES: The authorized individual named above may use this visit information to schedule, reschedule, cancel or confirm any and all visits for me.

DURATION: I understand this authorization may be revoked in writing at any time, according to the instructions in the RCHSD 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 one year from the date of this authorization.

RESTRICTIONS: I understand that RCHSD 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 RCHSD 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)

My signature below confirms my understanding that depending on the nature of my visit(s) with RCHSD, certain visit information pertaining to mental health care, alcohol and drug treatment and HIV testing and other sensitive information may be shared. Sensitive information includes, but is not limited to, information regarding reproductive health (such as contraception, pregnancy testing, sexually transmitted diseases (STDs). Note: If you do not wish to have this visit information shared, please do not sign this form.

SIGNATURE:

_____ _____

Signature of Patient (Patient Must be 18 years old or over) Date / Time

_____ _____

Area Code & Phone Number Witness