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

PLACE PATIENT ID LABEL INSIDE BOX

DT79600

Authorization for Use or Disclosure of Health Information

EXPLANATION: This form authorizes the use or disclosure of protected health information in the manner described below and is voluntary. Rady Children's Hospital San Diego cannot condition services on whether or not you sign this authorization except under limited circumstances, such as for services related to research, eligibility or enrollment determinations, or services performed solely to create information for an outside requestor (such as worker's compensation). In these circumstances, Rady Children's Hospital San Diego may refuse services unless you provide an authorization for the disclosure of your information. Please be aware that once your information leaves Rady Children's Hospital San Diego, Rady Children's 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 (Name and address of facility or individual): ____________________

____

☐ to furnish to {or} ☐ to obtain from
Name and address of facility or individual: ____________________

____

health records and information pertaining to medical history, mental or physical condition, services rendered, or treatment of:
(Name of Patient) ____________________ Date of Birth: ____________________
Dates of Service: ____________________
Location of Service: ☐ Physician Office ☐ Inpatient ☐ Outpatient ☐ Emergency ☐ Other ____________________

This authorization is limited to the following medical records and type of information:
☐ Discharge Summary ☐ History/Physical Examination ☐ Consultation Reports ☐ Progress Notes
☐ Laboratory Tests ☐ X-Ray Reports ☐ Photographs, videotapes, digital or other images and CD's
☐ Other (please specify any limitations): ____________________

USES: The requestor may use the medical records and type of information authorized only for the following purposes:
☐ Continuing Care ☐ Inspection of Record Only ☐ Legal Matter ☐ Insurance Claim ☐ Personal Copy
☐ Second Opinion ☐ Other (Please specify): ____________________

I specifically authorize release of:
☐ Mental health treatment information ☐ HIV test results ☐ Alcohol / drug treatment information

DURATION: I understand this authorization may be revoked in writing at any time, according to the instructions in the Rady Children's Hospital San Diego 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 Rady Children's Hospital San Diego 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 Rady 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)

SIGNATURE:

____________________ ____________________ ____________________
Signature Parent / Patient (if over 18 years old) | Date / Time | Witness

____________________ ____________________ ____________________
Relationship to Patient ID Required (if over 18 years old) | Area Code & Phone Number | Date / Time