*(Not to be used for the sole purpose of releasing medical information: Use Authorization for Use and Disclosure of Protected Health Information)*

Completion of this document authorizes the disclosure and/or use of individually identifiable health information as set forth below, consistent with California and Federal law concerning the privacy of such information.

**FAILURE TO PROVIDE ALL INFORMATION REQUESTED MAY INVALIDATE THIS AUTHORIZATION.**

Name of Patient: _____ Date of Birth: ___ / ___ / _____

**INFORMATION TO BE SHARED FROM:**
**CHOC Children's**
**Hospital Department/Unit:** _____
1201 W. La Veta Avenue, Orange, CA 92868

**INFORMATION TO BE SHARED WITH:** ***(Please be specific)***
Provider/Organization/Person Name: _____
Relationship: _____ Phone: _____ Fax: _____
Address: _____ State: _____ Zip: _____

Provider/Organization/Person Name: _____
Relationship: _____ Phone: _____ Fax: _____
Address: _____ State: _____ Zip: _____

Provider/Organization/Person Name: _____
Relationship: _____ Phone: _____ Fax: _____
Address: _____ State: _____ Zip: _____

**Purpose of Request:**
☐ School Management (ADD, IEP, Single Plan of Care, asthma or other chronic conditions) communicated with and released to school staff
☐ Coordination of community/social services
☐ Coordination of medical services where special authorization is required: mental health, alcohol, drug abuse/treatment, sexually transmitted diseases, HIV test results
☐ Other (specify) _____

**This Authorization Expires:**
☐ From the date of this authorization until ____/____/_____ (date must be specified)
☐ Until CHOC Children's fulfills this request
☐ Until the following even occurs (must be specific): _____

***CONTINUED ON REVERSE SIDE***

**Dates of Treatment:** _____

**Please Share the Following Information: check requested items**

Medical Information

☐ Diagnosis
☐ Current Medications
☐ Operative Report
☐ Discharge Summary
☐ Consultations
☐ Sexual History
☐ Substance Use History/Treatment
☐ Fertility Education & Information
☐ Medical Prognosis
☐ Immunizations
☐ Radiology Reports
☐ Mental Health Diagnosis/Treatment
☐ Laboratory Reports
☐ Do Not Resuscitate Preferences
☐ Treatment Plan
☐ History & Physical
☐ Radiology Images

Ancillary Services

☐ Psychology
☐ Spiritual Care
☐ Social Work
☐ Other _____
☐ Rehabilitation

- Neither treatment, payment, enrollment, or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.
- I may revoke this authorization at any time. My revocation must be in writing and forwarded to the CHOC Privacy Official, Health Information Management Department.
- My revocation will be effective upon receipt but will not be effective if CHOC has already processed original request for release of health information.
- I understand that I may inspect or obtain copies, for a fee, of the health information that is being released.
- I understand that once the above information is released the recipient may redisclose it and the information may not be protected by federal privacy laws or regulations. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required by law.

**I have a right to receive a copy of this authorization.**
Copy Requested: ☐ Yes ☐ No Initial: _____ Date: ____/____/_____

_____ ____/____/_____
Signature of Patient/Parent/Legal Guardian Date

_____ _____
Printed Name of Patient/Parent/Legal Guardian Relationship to Patient

Phone: _____