Email completed form to:HIM@choc.org

Authorization for School Clinician Access to Electronic Health Record (EHR)
For Completion by Parent of Patient/Student

FAILURE TO PROVIDE ALL INFORMATION MAY INVALIDATE THIS AUTHORIZATION

Completion of this form authorizes your child's school clinician to access your child's CHOC Electronic Health Record (EHR). The purpose of this access is to help your child's school clinician better manage your child's medical care in partnership with CHOC.

The EHR is an electronic database containing your child's medical history. If your child has received treatment relating to mental health or other sensitive conditions such as HIV/AIDS test results or status, this information may be viewable by your child's school clinician.

This authorization is valid from your date of signature through July 31st, 2026.

This form must be completed annually if you would like school clinician access to continue. Completion of this form is optional. If you choose not to complete this form, your child's school clinician will not have access to your child's EHR. Neither you or your child will be penalized if you choose not to complete this form.

Patient/Student Information (Please Print):

Last Name:	First Name:	Middle Name:	
Date of Birth (MM/DD/YYYY):			
Street Address:	City:	State:	Zip Code:

School Information (Please Print)

Name of School:	School District:
School Mailing Address:	
School Phone:	School Fax:
Printed Name of School Contact:	Email:

CONTINUED ON REVERSE SIDE

This form only authorizes EHR access to school clinicians pre-approved by CHOC to participate in this program.

998735 (5/2023)

CHOC

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- 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 Health Information Management Department at CHOC.
- 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 _____

Authorizing Parent

Name (Please Print):	**Relationship to Patient/Student:**	
Phone:	**Email:**	
Signature:	**Date:**	**Time:**

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CHOC HIM USE ONLY: **MRN:** _____

Proxy Access Granted By (Print Name): _____ Date: _____ / _____ / _____

998735 (5/2023)