PLEASE SEND THIS COMPLETED FORM TO:

Stanford Children's Health **HIMS Department**

Mailing Address: 4700 Bohannon Drive, 2nd Floor, Menlo Park, Ca. 94025, MC 5900
Via Email: HIMS-ROI@stanfordchildrens.org **Phone:** (650) 497-8079

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

When you complete and sign this form, health information about you will be released as you describe in the form. Please read each section carefully and complete the required sections before signing. We encourage you to request a copy of your records and review them before authorizing the release of the records to someone other than you. Please clearly and legibly print all information when completing this form and sign on the last page.

FACILITY/HEALTHCARE PROVIDER YOU WOULD LIKE YOUR RECORDS RELEASED FROM

I hereby authorize:
❑ **Lucile Packard Children's Hospital Stanford | Stanford Children's Health**
725 Welch Road, Palo Alto, CA 94025

❑ (Other Healthcare Provider)_____

SECTION A: PATIENT INFORMATION

Please print the name of the patient whose records are being requested for release.

*Patient's name: Last:*_____*First:*_____*M:*_____

*Date of birth:*_____ *Phone number:*_____*Medical Record number:*_____

Indicate if patient is part of multiple births: ❑Twin ❑Triplets ❑Other:_____

SECTION B: WHAT TYPE OF MEDICAL RECORDS?

Please describe the specific health information you would like released by completing the appropriate information on the following pages. Certain specific health information requires a separate indication from you in order for us to release that information, such as **HIV** test results, hereditary disorder test results, family planning services and certain mental health information. If you would like this information released, you will need to indicate separately in the boxes B.2, B.3, B.4, B.5 and B.6 below. You must both check the box and initial next to the box to authorize the release of the information described after the box.

REQUIRED ADOLESCENT CONSENT All record requests for protected confidential and sensitive services for Adolescent patients, aged 12-17 require a signed consent from the adolescent. Records will be reviewed by the provider prior to their release. Providers have the right to deny release if deemed appropriate. If you would like to request this information please complete section B.1 with dates of service and have **patient sign section I**, on page 6.

B.1: General Health Information Release (Please note: if you do not check any of the boxes in Sections B.2, B.3, B.4, B.5 or B.6 below and there is information in your record as described in those sections, the information described in those sections will not be included in the release if you simply check the boxes in B.1). However, we will include mental health records, except as described in B.2

- ❑ _____Check here **and initial** next the box if you would like information related to specific dates of service released and not the entire medical record. Indicate dates of service:_____
- ❑ _____Check here **and initial** next to the box if you would like to further describe the health information that you would like released, and please provide a description:_____
- ❑ _____Check here **and initial** next to the box if you would like your entire medical record released.
- ❑ _____Check here **and initial** next to the box if you would like your **Radiology Film or Radiology Film or Radiology compact disk** (CD) released. Request will be forwarded to the Film Library for processing. For questions, please call 650-497-8376
- ❑ _____Check here **and initial** next to the box if you would like **billing records or billing information** released. If requesting for billing records only, please mail directly to the SCH Patient Financial Services Dept., 4700 Bohannon Drive, 2nd Floor, Menlo Park, CA 94025, MC 5582. For questions, call 650-725-4433.

B.2: Mental Health Information

❑ _____Check here **and initial** next to the box if you had outpatient psychiatric services provided in the Outpatient Psychiatric Clinic located at 401 Quarry Road and you would like these records released. Please note that the physician, licensed psychologist, social worker or marriage/family therapist may deny access to records if deemed to have a detrimental effect on the professional relationship with the patient.

IMPORTANT NOTE ABOUT MENTAL HEALTH INFORMATION: If you received mental health services, such as a psychiatric consult, when you were an inpatient or when you were an outpatient in one of the outpatient clinics other than outpatient Psychiatric clinic at 401 Quarry Road, the mental notes in your general record will be released when you check the boxes in Section B.1. We will release all information in the general record as you indicate in B.1, which may include mental health notes if you were seen in location other
than the inpatient psychiatric unit or the outpatient psychiatric clinic. We will not exclude or redact information that is included in the general record for releases that you authorize under Section B. 1, including mental health notes in the general record. We encourage you to request a copy of your records and review them before authorizing the release of the records.

B.3: HIV Lab Test Results

❑ _____Check here **and initial** next to the box if you had HIV tests performed and would like the HIV test results released.

B.4: Hereditary Disorder Test Results

❑ _____Check here **and initial** next to the box if you had Hereditary Disorder tests performed and you would like the Hereditary Disorder test results released. Hereditary Tests include antenatal, neonatal, childhood and adult hereditary disorder screening records and/or related genetic counseling services that were provided in the Genetic counseling Department (all test results and records and/or related genetic counseling services that were provided in the Genetic counseling Department (all test results and records generated as part of the hereditary Disorders Program). The release of this information may involve the following risks; re-disclosure by the recipient of Hereditary disorder test results, loss or compromise of insurance benefits, or employment status. The release of this information may involve the following benefits: predetermination of genetic conditions, coordination of care, treatment options. You should consult your physician concerning the risk and benefits of specific tests.

B.5: Family Planning Services

❑ _____Check here **and initial** next to the box if you had California Family Planning, Access, Care and Treatment (FPACT) services and would like this information released. FPACT services may include clinical services, drug and supply services or laboratory services provided at the Gynecology Clinic (GYN) or the Reproductive Endocrinology and Infertility Clinic (REI). If a minor has received family planning services, the release of these records requires authorization from the minor.

B.6: SCH Non-Treating Physician Access To Electronic Medical Record

❑ _____Check here **and initial** next to the box if you authorize the following physician(s) who are not involved in you treatment to access your electronic medical record and you are not requesting the release of your printed medical record:

_____

SECTION C: <u>WHO/WHERE SHOULD RECORDS BE RELEASED TO?</u>

Please indicate the facility or person whom you authorize to receive the health information indicated on this form. Please note that if you wish to impose restriction on the recipient's use of the health information, you must contact the recipient directly.

*Name of person or facility to receive the health information:*_____

*Address:*_____

*Phone:*_____

SECTION D: <u>REASON FOR YOUR REQUEST</u>

Please indicate the reasons you would like your health information released.

❑ Check here if you are the patient or legal representative and you do not want to provide the reason.

❑ Check here if the release is not to the patient or legal representative and provide the reason for the release here_____

SECTION E: HOW WOULD YOU LIKE TO RECEIVE OR HAVE YOUR RECORDS SENT?

Please indicate how you would like this information sent to the recipient.

- ❑ Check here if you would like health information mailed to the recipient address in section C.
- ❑ Check here if you will pick up the health information at the hospital Health Information Management Services Department (HIMS). Please indicate how you would like to receive health information you are requesting: ❑ Paper Copy ❑ USB
  Please note: *Copies of requested health information will be billed according to current fee schedule.*
- ❑ Check here if you are not requesting a copy of your health information but would like to inspect your records in the HIMS Department. Someone from the HIMS Department will contact you to make these arrangements.
- ❑ Check here if this is an emergency situation (i.e. patient currently being treated at this time in medical facility) and you would like the health information faxed to the facility. Provide the fax number here_____. Faxing of medical records is available only in emergency situations.

SECTION F: EXPIRATION OF THIS AUTHORIZATION

This authorization becomes effective upon signing and will expire on (date)_____
Please note that if no date is indicated, this authorization will expire one (1) year from the signature date.

SECTION G: YOUR PRIVACY RIGHTS

- You may refuse to sign this authorization. Your refusal will not affect your ability to obtain treatment, insurance payment or eligibility for benefits.
- You have the right to withdraw or revoke this authorization in writing at any time, except to the extent that Stanford Children's Health has already released the health information. To withdraw or revoke your authorization, please submit your request in writing to Stanford Children's Health, Health Information Management Services (HIMS) Department, 4700 Bohannon Drive, 2nd Floor, Mail Code 5900, Menlo Park, Ca. 94025.
- Stanford Children's Health may deny your request to inspect and /or receive a copy of your health information under certain circumstances authorized by law. You will be notified of any such denial and of how you may appeal such denial.
- You have the right to receive a copy of this authorization.

SECTION H: CAUTIONS BEFORE SIGNING

Your health information that will be released as a result of you signing this authorization could be re-disclosed by the recipient. If this occurs, your re-disclosed health information may no longer be protected by state or federal privacy law.
We encourage you to request a copy of your records and review them before authorizing the release of the records to someone other than you.
The release of this information may involve certain risks, such as re-disclosure by the recipient, loss or compromise of insurance benefits or employment status.
If you have questions about this authorization form or the release of your health information, please contact the Stanford Children's Health HIMS Department at 650-497-8079

SECTION I: SIGNATURE AND DATE

Please sign and date this form to authorize Stanford Children's Health to release your information as stated on this form.

_____ _____
ADOLESCENT PATIENT SIGNATURE If required (see section B) Date

_____ _____
SIGNATURE (Patient, Parent or Properly Designated Representative) Date

_____ _____
PRINT NAME OF SIGNATOR RELATIONSHIP to Patient

*Address of patient or legal representative signing this form (please print):*_____

_____

*Phone number of patient of legal representative signing this form (please print):*_____

PLEASE SEND THIS COMPLETED FORM TO:

Stanford Children's Health HIMS Department

Mailing Address: 4700 Bohannon Drive, 2nd Floor, Menlo Park, Ca. 94025, MC 5900
Via Email: HIMS-ROI@stanfordchildrens.org

FOR OFFICE USE ONLY:

- ❑ Processed by (Print Name): _____ Date Processed: _____
  Department: _____ Phone#/Extension:_____
- ❑ Sent to HIMS for processing Date sent:_____

A COPY OF THIS AUTHORIZATION FORM MUST BE GIVEN TO THE REQUESTOR