Shriners Hospitals for Children®

Authorization for Disclosure of Health Information - California

Patient Name: _____

Medical Record #_____Date of Birth _____

Address:_____

_____

Telephone _____

For the period(s) of health care

from (date)_____ to (date)_____

from (date)_____ to (date)_____

1. I hereby authorize Shriners Hospitals for Children®,_____ to disclose to:

Name:_____

Street Address:_____

City, State & Zip Code:_____

2. Information to be disclosed:

- ☐ Discharge summary ☐ Progress notes ☐ Operative reports
- ☐ History & physical examination ☐ Laboratory tests
- ☐ Consultation reports ☐ X-ray reports ☐ X-ray films
- ☐ Photographs/slides ☐ Billing Statement ☐ Other_____

Policy # UDA-4

Patient Name & MR #:

3. Reason for disclosure:_____

_____

4. Separate signature required for release of information related to items below. Initial each line if required.

___ Acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV)

___ Behavioral health services/psychiatric care/psychotherapy records

___ Alcohol and substance abuse diagnosis and treatment records

___ Pregnancy, contraceptives, and sexually transmitted diseases

___ Genetics testing

Signature for release of information in Item 4:

_____

5. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. **Unless otherwise revoked, this authorization will expire one year (12 months) from the original date for release of information to family members; six (6) months from the original date for all other releases.**
6. I have had the opportunity to ask questions regarding this Authorization and these questions have been answered fully.

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Patient Name & MR #:

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7. I hereby release and agree to indemnify and hold harmless Shriners Hospitals for Children, it successors and assigns, and its agents and employees, from and against any claim or cause of action based on the release of requested health records and/or health information I previously authorized.
8. The recipient of this information might disclose it to other people. Shriners Hospitals for Children has no way to prevent this re-disclosure and cannot be held liable for such re-disclosures.

 I understand that I do not have to and have chosen not to sign this Authorization. My failure or refusal to sign will not affect my child's or my treatment or ability to receive treatment at Shriners Hospitals for Children.

_____
Signature of Patient (if 14 years of age or older)

_____
Signature of Father or Legal Guardian

_____
Witnessed by:

Date: _____

_____
Signature of Mother or Legal Guardian

_____
Witnessed by:

Date: _____

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Patient Name & MR #: