Release of Information Checklist

Please make sure that the authorization is complete in order to prevent any delay in processing your request:

Patient Name – Name of the patient you are requesting records for.

Date of Birth – Patient's from above date of birth.

Telephone – Best number to call you if there are questions and/or notification records are ready.

Name and Address of recipient – If you are requesting the medical record please provide your name and address: Example; Mary Smith 9300 Valley Children's Place. Madera, CA 93636. If you are requesting that the records be sent to another physician please provide that information on this line.

Purpose – Reason you are requesting the records.

Type of Information – Please check any/all document(s) and the date of service.

My Rights – Explanation of your rights to receive records.

Date – Date you are signing the authorization.

Time – Time you signed the document.

Signature – It is very important that you sign on this line as the Patient or Legal Representative.

Relationship – Please provide your relationship to the patient.

*From the date when the authorization is received, processing will take 7-10 business days. You will be notified when records are ready to be picked up or mailed.

For any questions please call 559-353-5404 Monday-Friday between 8-5.

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

9300 Valley Children's Place
Madera, California 93636
Telephone: 559-353-5404
Fax: 559-353-5418

Completion of this document authorizes the disclosure and/or use of individually identifiable health information as set forth below. **Failure to provide all information requested may invalidate this Authorization.**

I hereby authorize Valley Children's Hospital to use and disclose a copy of the specific health information identified below for:

_________________________________ _________________ (____)_________________

Patient Name ***Date of Birth*** ***Telephone***

To the following persons/organizations:

____

Name and Address of recipient authorized to receive the information.

For the following purposes:

Place an X on the line that applies:

Personal Use ______ To obtain additional benefits ____

Attorney Use ______ Payment of a claim ____

If none of the above applies, please state your purpose below:

____

I specifically authorize the use and/or disclosure of the following health information to the extent such information and/or medical records exist. Please specify what health information that you would like to request.

Type of Information	**[X] which apply**	**Dates Associated with the Information**
History & Physical (admission)		
Discharge Summary		
Consultations		
Operative Reports		
Clinic Summaries		
Laboratory Reports		
Radiology Reports		
Diagnostic Reports		
Billing Records		

Radiology Films		
Pathology Slides		
Visit History		
Other:________________		
Other:________________		

I request my records in the following manner:

CD ______ Paper _______

My Rights

I understand that treatment, payment, enrollment or eligibility for benefits will not be denied based solely on my refusal to provide this authorization, unless the following applies:

(i) the treatment is research-related and the recipient identified above is seeking to use the information to conduct such research;

(ii) the recipient is a health plan which seeks to obtain information (except psychotherapy notes) in connection with my eligibility or future enrollment in the health plan; or

(iii) the sole purpose of the treatment is to create health information to provide to the recipient identified above.

I understand that:

- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: Valley Children's Hospital, 9300 Valley Children's Place, Madera, CA, 93636
- There may be exceptions where the revocation of the authorization may not be able to be honored.
- There is a potential for the information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer be protected.
- Any valid written revocation received by Valley Children's Hospital shall not apply to information that has already been released pursuant to this authorization or affect actions taken by Valley Children's Hospital prior to such written revocation.

This authorization will expire on date: ______________________

Date: ____________________ Time: ______________AM/PM

Signature: ____

Patient/Legal Representative Signature

Please state your legal relationship to the patient: _________________________________

Witness: ____

Release of Information Staff Signature