

Authorization for Use or Disclosure of Health Information

EXPLANATION: This form authorizes the use or disclosure of protected health information in the manner described below and is voluntary. Children's Specialists of San Diego cannot condition services on whether or not you sign this authorization except under limited circumstances, such as for services related to research, eligibility or enrollment determinations, or services performed solely to create information for an outside requestor (such as worker's compensation). In these circumstances, Children's Specialists of San Diego may refuse services unless you provide an authorization for the disclosure of your information. Please be aware that once your information leaves Children's Specialists of San Diego, Children's will no longer be able to protect that information, and the recipients of your information may not be legally required to protect your information.

AUTHORIZATION: I hereby authorize (Name and address of facility or individual): _____

to furnish to {or} to obtain from
Name and address of facility or individual: _____

health records and information pertaining to medical history, mental or physical condition, services rendered, or treatment of:
(Name of Patient) _____ Date of Birth: _____

Dates of Service: _____

Location of Service: Physician Office Inpatient Outpatient Emergency Other _____

This authorization is limited to the following medical records and type of information:

- Discharge Summary History/Physical Examination Consultation Reports Progress Notes
- Laboratory Tests X-Ray Reports Photographs, videotapes, digital or other images
- Other (please specify any limitations): _____

USES: The requestor may use the medical records and type of information authorized only for the following purposes:

- Continuing Care Inspection of Record Only Legal Matter Insurance Claim Personal Copy
- Second Opinion Other (Please specify): _____

DURATION: I understand this authorization may be revoked in writing at any time, according to the instructions in the Children's Specialists of San Diego Notice of Privacy Practices, except to the extent that action had been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire six months from the date of this authorization.

RESTRICTIONS: I understand that Children's Specialists of San Diego may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. I hereby release Children's from any/all legal liability that may arise from the release of this information to the party named above.

ADDITIONAL COPY: I further understand that I have a right to receive a copy of this authorization upon my request. (Civil Code S.56.1f)

SIGNATURE:

Signature

Date

Witness

Relationship to Patient

Area Code & Phone Number

Info sent on: _____ Date _____ by: _____