Valley Children's HEALTHCARE

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

9300 Valley Children's Place
Madera, California 93636-8762
Telephone: 559-353-5404
Fax: 559-353-5418
Radiology Telephone: 559-353-5917
Radiology Fax: 559-353-6337

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		

Valley Children's HEALTHCARE

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.

(iv) 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
Mailstop: FE06

This authorization will expire on: _____.

Date: _____ Time: _____AM/PM

_____

Patient/Legal Representative Signature

Please state your legal relationship to the patient: _____

Witness: _____

Release of Information Staff Signature