Please send request to:
Stanford Hospital and Clinics (SHC)
HIMS Dept. - Rm HC029 MC: 5202
300 Pasteur Drive, Stanford, CA 94305 - 5200
Phone: (650) 723-5721 Fax: (650) 725-9821

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.

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SECTION A: Please provide 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:*_____

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SECTION B: Please describe the specific health information you would like released by completing the appropriate information below. 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.***

B.1: <u>General Health Information Release</u> (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 to 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 Compact Disk (CD) released.

☐ _____ Check here ***and initial*** next to the box if you would like your billing records or billing information released.

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STANFORD HOSPITAL and CLINICS (SHC)
LUCILE PACKARD CHILDREN'S HOSPITAL (LPCH)

AUTHORIZATION • RELEASE OF HEALTH INFORMATION

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

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

B.2: Mental Health Information

☐ ____ Check here ***and initial*** next to the box if you had inpatient psychiatric services provided in the G2 or H2 hospital unit and you would like these records released. Please note that the physician, licensed psychologist, social worker or marriage/family therapist who was in charge of the patient's care may deny release of your information in limited circumstances.

☐ ____ 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 who was in charge of the patient's care may deny release of your information in limited circumstances.

IMPORTANT NOTE ABOUT MENTAL HEALTH INFORMATION: If you received mental health services, such as a psychiatric consult, when you were an inpatient not on the G2 or H2 hospital inpatient psychiatric units or when you were an outpatient in one of the outpatient clinics other than Outpatient Psychiatric Clinic at 401 Quarry Road, the mental health 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 locations 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 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.

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AUTHORIZATION • RELEASE OF HEALTH INFORMATION

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

B.6: 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 your treatment to access your electronic medical record and you are not requesting the release of your printed medical record: _____

_____

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SECTION C: 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 restrictions 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:*_____

****

SECTION D: Please indicate the reason you would like your health information released.

☐ Check here if you are the patient and you do not want to provide the reason.

☐ Check here if the release is not to the patient and provide the reason for the release here _____

_____

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

☐ Check here if you would like the health information mailed to the recipient's address above.

☐ Check here if you will pick up the health information at the hospital Health Information Management Services Department (HIMS).

☐ 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 and you would like the health information faxed to the recipient and provide the fax number here_____. *Faxing of medical records is available only in emergency situations.*

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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.

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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 Hospital and Clinics has already released the health information. To withdraw or revoke your authorization, please submit your request in writing to Stanford Hospital and Clinics, HIMS Department Room H006 MC 5200, 300 Pasteur Drive, Stanford, CA 94305.

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

- Stanford Hospital and Clinics may deny your request to inspect and/or receive a copy of your health information under certain circumstances as 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.

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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 Hospital and Clinics HIMS Department at **650-723-5721** before signing this form.

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SECTION I: Please sign and date this form to authorize **Stanford Hospital and Clinics** to release your information as stated on this form.

Name of patient (please print): _____

Name of legal representative signing this form, if applicable (please print): _____

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

_____

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

If you are not the patient and you are signing this authorization form, describe your authority to sign on behalf of the patient and please provide supporting legal documentation:

_____

_____

Signature of patient or legal representative:

_____ *Date:* _____

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