Children's Health Council

Medical Record #: _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client Information

Client Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Email: _____

Communication/Disclosure Method (Please check all that apply)

☐ Verbal ☐ Mail ☐ Email ☐ Fax
☐ Other: _____

Purpose of Requested Use or Disclosure

☐ Client/Parent Request (or Legal Representative)
☐ Other: _____

Authorization – I hereby authorize the below to use/disclose information:

Children's Health Council
ATTN: Medical Records Dept.
650 Clark Way
Palo Alto, CA 94304
Phone: (650) 688-3614 FAX: (650) 688-3636 Email: medicalrecords@chconline.org

☐ **To Send to** ☐ **To Receive From** ☐ **Both Send/Receive With**

_____
(Name of person, organization, healthcare provider, school or other)

_____
Address City State Zip

_____
Phone Fax Email

Information Disclosure

☐ All records (Medical and/or Mental Health)
☐ Other/Specific records (please indicate types of records/information and date ranges):

_____

_____

Expiration

This authorization shall become effective immediately and shall remain in effect until the following date: _____. If no date is provided for expiration, this authorization shall remain in effect for (5) years from the date signed unless revoked earlier in writing. All authorizations signed by a parent or legal representative will expire once a client meets the legal age or requirement(s) to sign their own authorizations.

Your Rights

- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment or payment.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered/emailed to:
  Children's Health Council – 650 Clark Way Palo Alto, CA 94304
  Or medicalrecords@chconline.org
- My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.
- I have a right to receipt a copy of this authorization.
- I may inspect and obtain a copy of the health information of which I am authorizing the use or disclosure of my health information, subject to applicable state/federal laws.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure, in some cases, may not be protected by State and Federal law. Please note that if you wish to impose restrictions on the recipient's use of the health information, you must contact the recipient directly.

Signature (All fields below as required by law) – Please provide signature below solely to execute the above authorization. Not valid without a date signed.

SIGNATURE: _____ **Date**: _____
(Client or Parent/Legal Representative)

If signed by other than the client, print name and relationship:

Name: _____ Relationship: _____