Request/Authorization for Protected Health Information (PHI)

9300 Valley Children's Place, Madera, CA 93636-8762 FE06
Telephone: 559-353-5404 Fax 559-353-5418
ReleaseofInformation@valleychildrens.org

Fees may apply to certain requests. Failure to provide all information requested may invalidate this authorization.

Patient Name (First, Middle, Last): _____

Patient Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I authorize Valley Children's Hospital/Valley Children's Medical Group to release health information as follows:

Recipient Name &/or Organization: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Delivery and format Preference (Fees may apply)

☐ MyChart Patient Portal Do you want to sign up for MyChart today? ☐ Yes ☐ No

☐ CD ☐ USB ☐ Mail (USPS)

☐ Paper (No Charge for the First 250 pages, each page over 250 is $0.10 per page)

☐ Email: _____

☐ E-Fax: _____

This disclosure can be used for the following purpose(s):

☐ Personal Use ☐ Continuation of Care ☐ Insurance ☐ Attorney Use ☐ School

☐ Other: _____

Check ONLY one of the following options to identify the health information to be released

☐ **Option 1:** Last 2 years of all clinically relevant pertinent information

☐ **Option 2:** Records as specified. You must complete both Step A and Step B below:

Step A: Enter date range of date(s) of the records to be released: _____

Step B: Select types of records to be released.

☐ Emergency Department ☐ History & Physical ☐ Immunization ☐ Lab Results ☐ Clinic Notes ☐ Discharge Summary ☐ Pathology Reports ☐ Operative Reports

☐ Billing Records ☐ X-Ray/MRI Images ☐ Echocardiogram Images

☐ ECG/EKG readings ☐ Complete Designated Record Set (DRS) ☐ EHI Export

☐ Other: _____

Rev 9.1.2024

Optional Content: Requesting this information will cause turnaround time to increase to 10-14 days as additional permissions must be obtained. *Release of this information may be denied under certain circumstances.*

Check the boxes below if you want this release to include the following sensitive information, otherwise this information will be excluded.

☐ Psychology Notes ☐ Social Worker Notes ☐ Child Advocacy

If patient is 12 and over, the patient's signature is required for the following sensitive information:

☐ STDs/STIs, HIV, AIDS ☐ Sexual and/or reproductive Health Treatment

Patient Signature: _____

Expiration: This Authorization will automatically expire 1 year from the signature date. This authorization becomes effective upon signing and will expire on _____/_____/_____

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.

_____ _____

Printed Name of Personal Representative/Patient Relationship to Patient*

_____ _____

Signature of Personal Representative/Patient Date Time

*If the person signing this Authorization is other than Patient/Parent, attach documentation of authority.