Medical Record Number:

Patient Name:

Release of Electronic Health Information (EHI) Export File(s)

The EHI Export file(s) contain all of your medical and billing information found within your legal medical record and billing record through Stanford Medicine Children's Health & Packard Children's Health Alliance.

When you complete and sign this form, electronic health information (EHI) about you will be released as you describe in the form. Please read each section carefully and complete the required sections before signing. Please clearly and legibly print all information when completing this form and sign on the last page.

SECTION A: PATIENT INFORMATION

*Patient's Name: Last:*_____ *First:* _____ *MI:*_____

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

Indicate if patient is part of multiple births: ☐ **Twins** ☐ **Other:** _____
☐ **Triplets**

SECTION B: AUTHORIZATION

**Please check the box next to the manner in which you would like your information released.

YOU AUTHORIZE YOUR ELECTRONIC HEALTH INFORMATION (EHI) TO BE RELEASED IN THE FOLLOWING MANNER:

☐ **To your Stanford Medicine Children's Health electronic health portal (e.g., MyChart)**
☐ **Upload to a USB storage device**

Please specify the one person or institution you authorization to receive your health information.

DISCLOSE TO:_____
(Person/organization authorized to receive the information)

at the following address:_____
(Street)

_____
(City, State and Zip Code)

SECTION C: THE HEALTH INFORMATION

Please describe the specific health information you would like released by completing the appropriate information on the following pages. Certain specific health information requires a separate indication from you in order for us to release that information, such as genetics information (e.g., hereditary disorder test results), sensitive labs (e.g., HIV), sensitive/confidential information (e.g., Family Planning Services), and certain mental health information. If you would like this information released, you will need to indicate separately in the boxes C.1, C.2, C.3, and C.4 below. **You must both check the box and initial next to the box to authorize the release of the information described after the box.**

The EHI Export File(s) cannot be separated based on a specific date range (it will include all of your medical history) or the specific Stanford Medicine Children's Health entity where you received care.

☐ _____ Check here ***and initial*** next to the box if you would like your entire medical record and billing record released.

C.1: Mental Health Information

☐ _____ Check here ***and initial*** next to the box if you had psychiatric services provided in any SMCH Psychiatric Clinics and you would like these records released. Please note that the physician, licensed psychologist, social worker or marriage/family therapist may deny access to records if deemed to have a detrimental effect on the professional relationship with the patient.

IMPORTANT NOTE ABOUT MENTAL HEALTH INFORMATION: If you received mental health services, such as a psychiatric consult, when you were an inpatient or when you were an outpatient in one of the outpatient clinics other the Outpatient SMCH Psychiatric clinics, the mental health notes in your general record will be released when you check the box to release your entire medical record. We will release all information in the general record 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, 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.

C.2: Sensitive Labs (e.g., 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.

C.3: Genetic Information (e.g., Hereditary Disorder Test Results)

☐ _____Check here ***and initial*** next to the box if you had Hereditary Disorder tests performed and would like them released. Hereditary Tests include antenatal, neonatal, childhood and adult hereditary disorder screening records and/or related genetic counseling services 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 and treatment options.

C.4: Confidential Information (e.g., Family Planning Services)

☐ _____Check here ***and initial*** next to the box if you would like your confidential information records released. These confidential records consist of, but is not limited to: social history, sexual history, substance use, and abuse information that could be found in confidential records. Additionally, if you had California Family Planning Access, Care and Treatment (FPACT) services performed (which may include clinical services, drug and supply services, or laboratory services provided at the Gynecology Clinic [GYN] or the Reproductive Endocrinology and Infertility [REI] Clinic), these records would be included. If a minor has received family planning services, the release of these records requires authorization from the minor.

Please note that the physician, licensed psychologist, social worker or marriage/family therapist who was in charge of your care may deny release of your information.

SECTION D: EXPIRATION

This authorization will automatically expire once the EHI export is provided by Stanford Medicine Children's Health.

SECTION E: YOUR PRIVACY RIGHTS & EHI EXPORT CONSIDERATIONS

- You may refuse to sign this authorization. Your refusal will not affect your ability to obtain treatment or insurance payment or eligibility for benefits.
- You may revoke this authorization at any time prior to the EHI export file(s) release. This authorization will expire upon release of the EHI export file(s).
- You have a right to receive a copy of this authorization.
- The information in the exported file may not be understandable to you - the raw data is intended, and formatted for computer-readability only;
- The export file may contain information that you may not have discussed with your provider(s);
- The export file may contain information that you do not want shared with others; and
- The export file may contain unanticipated, unforeseen errors (e.g., inadvertent shifts in text/data, information not intended for disclosure, missing information, or other errors).

SECTION F: CAUTIONS BEFORE SIGNING

- Your health information that will be disclosed 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. Please note that if you wish to impose restrictions on the recipient's use of the health information, you must contact the recipient directly.
- If you have questions about your privacy rights, please contact the Stanford Health Care Compliance & Privacy Department at 650-724-2572.
- If you have questions about this authorization form, please communicate with the Stanford Health Care Compliance & Privacy Department. If you have questions regarding the release of your medical record information, please contact the Stanford Medicine Children's Health HIMS Department at 650-497-8079.

SECTION G: CONFIRM AUTHORIZATION

Please sign and date this form to authorize Stanford Medicine Children's Health 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):_____

Relationship to patient: _____

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.

(For Office Use Only)

Patient/Representative Identification Verified: ***SMCH ROI Staff Initials:***_____

Stanford Medicine Children's Health (SMCH) Health Information Management Services 4700 Bohannon Drive Mail Code 5900 Menlo Park, CA 94025 Phone: 650-497-8079