Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

STANFORD HOSPITAL and CLINICS
LUCILE PACKARD CHILDREN'S HOSPITAL
STANFORD, CALIFORNIA 94305

CORE DATA • GENERAL AUTHORIZATION

Stanford Hospital and Clinics and Lucile Packard Children's Hospital (the Hospital) understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we may use or disclose your protected health information for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form.

USE(S) AND DISCLOSURE(S) COVERED BY THIS AUTHORIZATION

A representative of the Hospital must answer these questions completely before providing this authorization form to you. ***DO NOT SIGN A BLANK FORM****. You or your personal representative should read the descriptions below before signing this form.*

Who will use or disclose your information? The person(s) and/or class of persons authorized to use or disclose your information are described below.

_____

_____

_____

If your information is disclosed, who will receive/use it? The person(s) or class of persons authorized to receive or use your information are described below.

_____

_____

_____

What information will be used or disclosed? The descriptions below should be in enough detail so that you (or any organization that must disclose information according to this authorization) can understand what information may be used or disclosed.

_____

_____

_____

What is the purpose of the use or disclosure? The purposes for which your information will be used or disclosed are described below.

_____

_____

When will this authorization expire? The date or event that will trigger the expiration of this authorization should be described below.

_____

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LUCILE PACKARD CHILDREN'S HOSPITAL
STANFORD, CALIFORNIA 94305

CORE DATA • GENERAL AUTHORIZATION

SPECIFIC UNDERSTANDINGS

By signing this authorization form, you authorize the use or disclosure of your protected health information as described above. This information may be re-disclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information. California law prohibits recipients of your health information from re-disclosing such information except with your written authorization or as specifically required or permitted by law.

You have a right to refuse to sign this authorization. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form. You also have a right to receive a copy of this form after you have signed it.

If you sign this authorization, you will have the right to revoke it at any time, except to the extent that the hospital has already taken action based upon your authorization. To revoke this authorization, please write to SHC/LPCH Privacy Office, 300 Pasteur Drive, Stanford, CA 94305-5202.

SIGNATURE

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.

_____ _____

Signature of Patient / Personal Representative Date

_____

Print Name of Patient / Personal Representative

If signed by Personal Representative, indicate relationship to patient or authority to sign:

_____

CONTACT INFORMATION

The contact information of the patient or personal representative who signed this form should be filled in below.

Address:_____

Phone Number:_____

If interpreted:_____ _____ _____

Interpreter Signature *Print Name* *Language*

_____ _____ _____

Date *Time* *Position/Relationship to Patient*

THE PATIENT OR HIS OR HER PERSONAL REPRESENTATIVE MUST BE PROVIDED WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED.

Internal Use Only

Signature of Workforce Member: _____ Date: _____

Name of Workforce Member who Completed Form: _____

Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

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Phone Number:_____

If interpreted:_____ _____ _____

Interpreter Signature *Print Name* *Language*

_____ _____ _____

Date *Time* *Position/Relationship to Patient*

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Internal Use Only

Signature of Workforce Member: _____ Date: _____

Name of Workforce Member who Completed Form: _____