VERT-LAC Color**DCFS/LAC+USC Medical Records Request**

**Los Angeles County Department of Children and Family Services (DCFS)**

**Los Angeles County Department of Health Services (DHS)**

***Request to LAC+USC from DCFS (to be completed by DCFS):***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date: |  | From: | , CSW | | |
| To: | LAC+USC Release of Information Office | Fax: |  | | |
| Fax: | (323) 441-8127 | Phone: |  | | |
| Phone: | (323) 409-6850 | SCSW: |  | | |
| Number of Pages Including this Page: | |  |  | | |
| **Specify Legal Authority for Request:**  The patient named below has been placed in the care and custody of DCFS (CC 56.103) OR  DCFS is requesting medical information as part of an ongoing child abuse investigation  (Penal Code 11167(b) or WIC 830 and 18951) OR  Authorization (DCFS 179-PHI or other authorization attached) OR  Court order (attached) | | | | **Please Process as:**  **Routine Request (within 5 business days)**  **Urgent Request (within 48 hours)** |
| **Return Records By:**  **Mail (preferred)**  **Fax**  **Hold for Pick-up** |

**PATIENT INFORMATION**:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient Name (last, first, middle): | | | | |
| Date of Birth: | DCFS CPH Referral Number (19 digits) or Case Number (7 digits): | | LAC+USC Medical Record Number (if known): | |
| Address | | | | |
| City: | State: | Zip: | | Phone: |

**INFORMATION REQUESTED** (Check all that apply):

|  |  |
| --- | --- |
| Clinic visit notes  Emergency Room Report  Surgical (operative report, path report)  Hospitalization (H& P, Consult, Tests, Surgical, Discharge Summary)  X-ray Films, Diagnostic Scans on CD’s (MRI, PET, CT, ultrasound, bone scan)  Test results (Specify: Lab, X-ray, EKG, etc.) | Complete Medical Record  CalEMA 2-900 and/or CalEMA 2-925 Reports  Therapy Notes (Specify: PT, Speech, Radiation, Chemo, etc.)  Records related to a specific injury with the following date (e.g. workers’  compensation injury): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| For the following dates of treatment: (for example: specific date 4/25/11 or; range of dates Jan-July 2011 or; all dates of service). | |
| Please provide the following information (Be SPECIFIC): | |

**RETURN RECORDS TO:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Requestor Name: | | | DCFS Office: | | |
| Office Address/Room Number: | | | | | City: |
| State: | Zip: | Phone: | | Fax: | |

***Response to DCFS from LAC+USC (to be completed by LAC+USC):***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date: |  | From: | LAC+USC Release of Information Office | |
| To: | , CSW | Fax: | (323) 441-8127 | |
| Fax: |  | Phone: | (323) 409-6850 | |
| Phone: |  | Number of Pages Including this Page: | |  |
| Comments: |  |  | |  |

Please refer to DCFS Procedural Guide 0600-500.20, Protected Health and Medical Information: Access and Sharing: http://www.lacdcfs.org/policy/hndbook%20cws/0600/060050020PMIv1009.doc

**NOTICE TO RECIPIENT:** If you are not the intended recipient of this FAX, you are prohibited from sharing, copying, or otherwise using or disclosing its contents. If you have received this FAX in error, please notify the sender immediately by telephone and destroy this FAX and any attachments without reading or sharing them. Thank you