MemorialCare™

☐ Long Beach Medical Center
☐ Miller Children's & Women's Hospital Long Beach
☐ Community Medical Center
☐ Orange Coast Medical Center
☐ Saddleback Medical Center

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

1. I hereby authorize MemorialCare and/or its entity(ies) to use or disclose my health information as follows:

Patient Name: _____ **Date of Birth:** _____

Address (Street, City/State, Zip): _____

Phone: _____ **SSN (last 4 digits):** _____

Date(s) of Service: _____

☐ Complete Medical Record ☐ Pertinent Medical Record (Dictated Reports/Test Results)

[**OR** the individual records marked below:]

☐ History & Physical ☐ Consultation Reports ☐ Progress Notes ☐ Discharge Summary
☐ Laboratory/Pathology Reports ☐ EKG's ☐ ECHO (Cardio) Tapes/Results
☐ Radiology Reports ☐ Radiology Films ☐ Operative Reports
☐ Billing Records ☐ Photographs, videotapes, or digital or other images
☐ Personal Health Profile (Please Include Name of Employer) _____
☐ Other: _____

2. ***Specific Authorization to Release Sensitive Records***

I understand that this consent is to include disclosure of: ☐ HIV/AIDS ☐ Psychiatric Records
☐ Alcohol and/or Drug Abuse Records ☐ Sexually Transmitted Disease Information
Patient/Patient Representative: _____ Relationship (if not patient): _____

3. Purpose of the requested use or disclosure (information will be used for):

☐ Patient/Representative Use ***or*** ☐ Other (please specify) _____

Limitations, if any _____

4. Please issue records by: ☐ CD ***or*** ☐ Paper

5. I am requesting that the records identified above be handled in the following manner:

☐ Mail To Address Listed Above ☐ I will pick-up ☐ Fax Number/Attn:_____
☐ A *Representative* will pick-up on my behalf (list name of *Representative*): _____
Mail information to: ☐ Clinic ☐ Dr. Office ☐ Hospital ☐ Attorney ☐ Other
Name/Address/Phone: _____

_____

_____

6. Unless otherwise revoked, or an alternative expiration date is provided here, _____ this authorization is valid for ninety days (90). Initials: _____

7. Individual Rights:

a. I may refuse to sign this Authorization;

b. I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf and delivered to the Medical Records Department of the applicable MemorialCare entity identified below:

Long Beach Medical Center / Miller Children's & Women's Hospital 2801 Atlantic Avenue, Long Beach, CA 90806; (562) 933-2000
Community Medical Center 1720 Termino Avenue, Long Beach, CA 90804; (562) 933-9000
Orange Coast Medical Center 9920 Talbert Avenue, Fountain Valley, CA 92708; (714) 378-7000
Saddleback Medical Center 24451 Health Center Drive, Laguna Hills, CA 92653; (949) 837-4500

c. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization;

d. I have a right to receive a copy of this authorization.

e. I may inspect or obtain a copy of the health information that I am being asked to use or disclose;

f. Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on me signing this authorization.

_____ _____ _____

Patient/Patient Representative Signature Date Time

_____

(Relationship If Signed by other than Patient)

_____

Name of Witness (Please Print)

(If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.)

FOR FACILITY USE ONLY

☐ Checked/Copied Patient ID

☐ Checked/Copied Representative ID

☐ Validated Patient Signature with _____.

☐ Contacted Patient for Approval to Release Records to Representative

☐ Received copy of Durable Power of Attorney/Advance Directive/Death Certificate