

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

#1 <i>Patient information</i>	Patient Information: Patient's Legal Name: _____ Date of Birth _____ Address (Street): _____ City/State/Zip Code: _____ Phone: _____ SSN (Last 4 digits): _____
#2 <i>Location of treatment</i>	I hereby authorize to use or disclose my health information as follows: Requesting Records From (Name of Physician/Clinic/Hospital): _____ Address: _____ City/State/Zip Code: _____ Phone: _____ Fax: _____
#3 <i>Where and to whom do you want records sent?</i>	Releasing Records To (Name of Person/Physician/Hospital): _____ Address: _____ City/State/Zip Code: _____ Phone: _____ Fax: _____ Email: _____
#4 <i>Reason for requesting records</i>	Records Needed For: ☐ Personal Use ☐ Continuation of Care ☐ Other _____
#5 <i>Select the date(s) of treatment and record(s) that you need</i> <i>**pertinent includes: notes and test results</i>	Please Select Options Below: Dates of Treatment Being Requested: _____ ☐ History and Physical ☐ Consultation Reports ☐ Operative/Procedure Reports ☐ Discharge Summary ☐ EKGs ☐ Other: _____ ☐ Office/Visit Notes ☐ Radiology Reports ☐ Laboratory/Pathology Results ☐ Billing Records ☐ Pertinent Records** ☐ Complete Records
#6 <i>If you need imaging, select which type</i>	Imaging: ☐ Radiology ☐ Mammogram ☐ Cardiology ☐ EEG ☐ Other _____
#7 <i>Authorization for specific sensitive information</i>	**Specific Authorization to Release Sensitive Records* I understand that this consent is to include disclosure of: ☐ HIV Test Results ☐ Genetic Tests ☐ Psychiatric Therapy Notes ☐ Alcohol and/or Drug Abuse Program Treatment notes Patient/Patient Representative Signature _____ Relationship (if not patient) _____

#8 Delivery Preference	Please Release Records On: ☐ MyChart ☐ CD ☐ USB ☐ Paper Deliver By: ☐ Email ☐ Fax ☐ Mail <i>Please note the processing cost for records issued for personal use: \$0.25 per page for paper copies. \$6.50 per CD/USB.</i>
#9 Expiration Date or how long is this authorization valid?	Unless otherwise revoked, or an alternative expiration date if provided here, _____ this authorization is valid for ninety days (90). Initials: _____

****Please note that incomplete forms may cause a delay in processing****

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:

MemorialCare Health Services: Long Beach Medical Center – Miller Children’s & Women’s Hospital – Community Hospital Long Beach – Orange Coast Medical Center – Saddleback Medical Center

(657) 241-7001 – Fax (657) 276-4774 – MHSIMMedicalRecords@memorialcare.org

MemorialCare Medical Group

(714) 665-1647 – Fax (714) 665-4681 – MedicalRecords@memorialcare.org

- 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.)