MemorialCare
Medical Group

To Request a Copy of Your Medical Records:

Complete the attached form **"Authorization to Use and Disclose Protected Health Information."**

Section 1 is asking you for demographic information. Please enter the following: name, address, phone, date of birth, last 4 digits of social security number, date(s) of service.

Section 2 Please enter the name of the Provider or Medical Group who you are authorizing to disclose your health information, please include fax number.

This Section is asking you, "What part of the medical record do I need?" The complete medical record contains every entry into our electronic system and may be considerably more information than you need. If you want more specific and/or limited information, choose the appropriate items under [**OR** the records marked below:]**,** i.e. Consultation Reports, Laboratory/Pathology Reports, Radiology Reports, etc. **Please include the time period to disclose.**

Section 3 needs to be completed if you are asking for records that are outlined in this Section. If you are asking for these records, then choose the appropriate item and **include your signature where indicated**. **If you are not** requesting records outlined in this Section, you do not need to complete this area of the form.

Section 4 is asking you if you would like your copies burned on a CD or printed on paper. Cost for Processing: A fee of $0.25 per page and applicable postage fees will be assessed for paper copies. If you would like your information placed on a "CD", a $5.00 fee applies. No fees will apply when medical records are being disclosed from MemorialCare Medical Group to a medical provider. If you have questions related to the cost of obtaining your records, please call (714) 665-1647.

Section 5 is asking you, "How would like your request to be handled?" Please be advised that in order to process your request, a valid Photo ID with signature, must be included with your authorization form.

If you want someone to pick up your records on your behalf, please include the name of your *Representative* in the space provided. **Please instruct your Representative that they must present a valid Photo I.D. matching the name listed in this section to obtain your records.**

If you want the information to be faxed, please provide the fax number

Section 6 is asking you the purpose of the request for use or disclosure (i.e. further medical treatment, personal use, attorney etc.)

Section 7 wants to know "How long this authorization is valid?" If you do not list a specific date in the space provided, the authorization will be valid for a period of 90 days from the date of your signature. **This Section requires that you provide our initials in the space provided.**

Section 8 outlines your *Individual Rights* as they pertain to this Authorization form

Signature/Date/Time: In order to process your request, this Section must be completed.

Submit the completed authorization form in person, by fax or mail to the following address. Please note that if authorization is not complete it will delay the process.

MemorialCare Medical Group
Attention: Medical Correspondence
2742 Dow Ave.
Tustin, CA 92780
Phone: (714) 665-1647
Fax: (714) 665-1644
Hours: 8:00 AM to 4:00 PM

MemorialCare™
Medical Group

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

1. Patient Information

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

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

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

2. I hereby authorize to use or disclose my health information as follows:

Records disclosed FROM	**Records disclosed TO**
_____ Name of Physician / Facility	_____ Name of Person / Physician / Facility
_____ Address	_____ Address
_____ City State Zip	_____ City State Zip
Phone: _____ Fax: _____	Phone: _____ Fax: _____

Please send the following records for this time period: _____ to _____

☐ Pertinent Medical Record (Dictated Reports/Test Results)

☐ Complete Medical Record (MCMG's policy is the last two years, unless otherwise requested).

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

☐ Consultation Reports ☐ Office Notes

☐ Laboratory/Pathology Reports ☐ EKG's

☐ Radiology Reports ☐ Radiology Films

☐ Billing Records ☐ Photographs, videotapes, or digital or other images

☐ Personal Health Profile (Please Include Name of Employer) _____

☐ Other: _____

3. *Specific Authorization to Release Sensitive Records*

I understand that this consent is to include disclosure of: ☐ HIV Test Results

☐ Psychiatric Therapy Notes ☐ Alcohol and/or Drug Abuse Program Treatment Notes

Patient/Patient Representative: _____ Relationship (if not patient): _____

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

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

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

Limitations, if any _____

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

8. 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 Medical Group 2742 Dow Avenue, Tustin, CA 92780; (714) 665-1647

   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.)