To Request a Copy of Your Medical Records:

1) Complete the attached form “Authorization to Use and Disclose Protected Health Information.”
   a. **Demographic Information.** Please enter the following: name, address, phone, date of birth, last four digits of your Social Security Number.

   b. **Section 1** asks, “What part of the medical record do I need?” The complete medical record contains every entry in 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. History & Physical, Operative Report, Discharge Summary, etc.

   c. **Section 2** does not need to be completed unless 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.

   d. **Section 3** asks, “How would you 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.

      i. 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.**

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

      iii. If any of the information is being faxed or sent to someone other than yourself; provide the name and address of the person who will receive your information.

   e. **Section 4** asks, “How long is 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 your initials in the space provided.**

   f. **Section 5** outlines your **Individual Rights** as they pertain to this authorization form.

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

2) **Cost For Processing:** A fee of $0.25 per page will be assessed for paper copies. If you would like your information placed on a CD, a $5.00 fee applies. If you have questions related to the cost of obtaining your records, please contact the facility directly.
3) Submit the completed authorization form in person, by fax or mail to the appropriate Medical Records Department where you received your care and treatment.

**Long Beach Memorial Medical Center**  
**Miller Children's Hospital Long Beach**  
2801 Atlantic Avenue  
Long Beach, CA 90806

Phone: (562) 933-1141  
Fax: (562) 933-1185  
Hours: 8:00 AM to 4:00 PM

**Community Hospital Long Beach**  
1720 Termino Avenue  
Long Beach, CA 90804

Phone: (562) 494-0646  
Fax: (562) 498-4443  
Hours: 8:00 AM to 5:00 PM

**Orange Coast Memorial Medical Center**  
9920 Talbert Avenue  
Fountain Valley, CA 92708

Phone: (714) 378-7440  
Fax: (714) 378-7494  
Hours: 8:00 AM to 4:00 PM

**Saddleback Memorial Medical Center**  
**Laguna Hills**  
24451 Health Center Drive  
Laguna Hills, CA 92653

Phone: (949) 452-7050  
Fax: (949) 837-4621  
Hours: 8:00 AM to 4:00 PM

**Saddleback Memorial Medical Center**  
**San Clemente**  
654 Camino de Los Mares  
San Clemente, CA 92673

Phone: (949) 489-4593  
Fax: (949) 489-4643  
Hours: 8:00 AM to 4:00 PM
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
   □ 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) __________________________

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 Memorial Medical Center / Miller Children’s Hospital Long Beach  |
|-------------------------------|-------------------------------|-------------------------------|
| 2801 Atlantic Avenue, Long Beach, CA 90806                               |
| (562) 933-2000                                                              |

| Community Hospital Long Beach                                              |
|-------------------------------|-------------------------------|-------------------------------|
| 1720 Termino Avenue, Long Beach, CA 90804                                  |
| (562) 498-1000                                                              |

| Orange Coast Memorial Medical Center                                      |
|-------------------------------|-------------------------------|-------------------------------|
| 9920 Talbert Avenue, Fountain Valley, CA 92708                            |
| (714) 378-7000                                                              |

| Saddleback Memorial Medical Center – Laguna Hills Campus                   |
|-------------------------------|-------------------------------|-------------------------------|
| 24451 Health Center Drive, Laguna Hills, CA 92653                         |
| (949) 837-4500                                                              |

| Saddleback Memorial Medical Center – San Clemente Campus                   |
|-------------------------------|-------------------------------|-------------------------------|
| 654 Camino de Los Mares, San Clemente, CA 92673                          |
| (949) 496-1122                                                             |

   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 ____________________________ Date ________ Time ______

(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.)

(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.)

(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.)