AUTHORIZATION TO RELEASE COPIES OF MEDICAL RECORDS
Hoag Memorial Hospital Presbyterian

Dear Patient:

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization:

Notice of Rights and Other Information:

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to Hoag Hospital, Health Information Department, One Hoag Drive, Newport Beach, CA 92658. My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance on this authorization.

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

- Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

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

Patient Name: _____

Date of Birth: _____

Use of disclosure: I hereby authorize Hoag Memorial Hospital Presbyterian to disclose the information listed below to: (List the person/organization authorized to receive this information.)

Name/Organization: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

☐ Mail ☐ Patient will pick up

☐ Family member will pick up: Name: _____ Phone: _____

Requested Media: ☐ Paper ☐ CD

This authorization applies to the following:

☐ All health information pertaining to any medical history, mental or physical condition and treatment received, OR

☐ Only the following records or types of health information: Date of Service: _____

☐ ED Records ☐ History & Physical ☐ Consults ☐ Operative Report

☐ Discharge Summary ☐ MD Progress Notes ☐ MD Orders ☐ Nurse's Notes

☐ EKG, EMG, EEG ☐ Radiology Reports ☐ Anesthesia Records ☐ Lab/Pathology Reports

☐ Radiology Film/CD, Type: _____ ☐ Other: _____

I specifically authorize release of the following information (check as appropriate):

☐ Alcohol/drug treatment information ☐ HIV Test Results ☐ Mental Health Treatment Information

A separate authorization is required to authorize disclosure or use of psychotherapy notes.

Purpose for use/disclosure: ☐ Patient Request ☐ Further Medical Care ☐ Insurance OR ☐ Other: _____

Expiration: This authorization expires (insert date): _____

Signature: _____ Date: _____ Time: _____AM/PM
[Patient/Legal Representative]

If signed by other than patient, indicate legal relationship to patient: _____

Print Name (Legal Representative): _____

Processed by: _____ Date: _____ Time: _____