MemorialCare™

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 _____

- ☐ History and Physical
- ☐ Operative/Procedure Reports
- ☐ Office Notes
- ☐ Radiology Results
- ☐ Billing Records
- ☐ Complete Medical Record
- ☐ Other:_____
- ☐ Discharge Summary
- ☐ Consultation Reports
- ☐ Laboratory/Pathology Results
- ☐ EKG's
- ☐ Radiology Images
- ☐ Other Imaging; please specify below

3. ***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: _____ Relationship (if not patient): _____

4. Please issue records by: ☐ CD ☐ USB ☐ Paper ☐ MyChart ☐ Email _____

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

☐ Mail to address listed above ☐ Fax Number/Attn: _____

☐ 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 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 • MHSHIMMedicalRecords@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.)

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