MemorialCare™

☐ Community Hospital Long Beach
☐ Long Beach Medical Center
☐ MemorialCare Medical Group
☐ Miller Children's & Women's Hospital Long Beach
☐ Orange Coast Medical Center
☐ Saddleback Medical Center

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

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

☐ Consultation Reports
☐ Laboratory/Pathology Reports
☐ Radiology Reports
☐ Billing Records
☐ Office Notes
☐ EKG's
☐ Radiology Films
☐ Photographs, videotapes, 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 ☐ 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 ☐ 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 Health Services: Long Beach Medical Center • Miller Children's & Women's Hospital Community Hospital Long Beach • Orange Coast Medical Center • Saddleback Medical Center 17360 Brookhurst Street, Fountain Valley, CA 92708 • (657) 241-7000 • fax (657) 276-4774
MemorialCare Medical Group 17360 Brookhurst Street, Fountain Valley, CA 92708 • (714) 665-1647 • fax (714) 665-4681

   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