STEP-BY-STEP INSTRUCTIONS TO COMPLETE THE REQUEST FOR RECORDS

Name and Date of Birth of patient is needed →

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 and Address of where you want your records sent →

Name/Organization: _____

Address: _____

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

Checking one of these boxes tells us how you want to receive the records →

☐ Mail ☐ Patient will pick up

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

Requested Media: ☐ Paper ☐ Secured Email: _____

☐ CD ☐ MyChart (services on or after 4/28/18)

This authorization applies to the following:

All records/all dates of service →

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

Specific records requested (give approximate date if unknown) →

☐ 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: _____

Special consent to release sensitive records. Check if applicable. →

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.

This is what you are using the records for what purpose →

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

☐ Other: _____

How long you want this authorization to last →

Expiration: This authorization expires (insert date): _____

IMPORTANT You MUST sign your request – unsigned requests cannot be processed. →

Signature: _____ Date: _____ Time: _____AM/PM

[Patient/Legal Representative]

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

Print Name (Legal Representative): _____