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

Name and Date of Birth of patient is needed →

Patient Name: _____ Date of Birth: _____

I hereby authorize **Hoag Memorial Hospital Presbyterian, or its affiliates and affiliated providers** 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: _____

Select the media type →

Please select the type of format the records should be in:

☐ Paper ☐ CD ☐ USB

Now select how you would like to receive the records →

Please select how you would like to receive the records:

☐ Mail to the address above

☐ Patient will pick up

☐ I authorize _____ to pick up my medical record copies.

For electronic options, select one →

Or you may receive the records electronically (please select):

☐ Secured Email: _____

☐ MyChart (patient portal)

☐ Secure Medical Image Exchange (Radiology/Cardiology images only): Email: _____

Dates(s) of service →

This authorization applies to the following: Date(s) of Service: _____

Specific records requested (give approximate date if unknown) →

☐ ED/Urgent Care Records ☐ History & Physical ☐ Consults ☐ Operative Report

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

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

☐ Immunizations ☐ Radiology Images, Exam: _____

☐ Outpatient/Clinic Record – Clinic/Provider Name: _____

☐ Other: _____

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

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

☐ Substance Use Disorder treatment information ☐ HIV Test Results

☐ Mental Health Treatment Information

A separate authorization is required to authorize the 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 will expire in 1 year from date of signature unless another date or event is specified:

_____

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

Patient/Legal Representative Signature: _____ Date: _____ Time: _____ AM/PM

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

Print Name (Legal Representative): _____

AUTHORIZATION TO RELEASE COPIES OF MEDICAL RECORDS | Original – Chart | Copy – Patient

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