AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient's Name: _____
Last First Middle

Home Address: _____
Street

_____ _____ _____
City State Zip Code

Home Telephone: _____ Date of Birth: _____

SPECIFY INFORMATION TO BE RELEASED:

The information that may be disclosed under this Authorization includes: _____

☐ Laboratory/Pathology Reports ☐ Operative Reports
☐ Radiology Reports ☐ Radiology Images
☐ Billing Records ☐ Emergency Medical Reports
☐ Other _____

MY HIGHLY CONFIDENTIAL INFORMATION:

By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

☐ Information about mental health or mental retardation services
☐ Psychotherapy Notes created by a mental health professional
☐ Information about HIV/AIDS-related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
☐ Information about sexually transmitted diseases
☐ Information about alcohol or drug abuse treatment program services
☐ Information about sexual assault
☐ Information about child abuse and neglect

RECIPIENT:

Name of person or class of persons to whom MARINA DEL REY HOSPITAL may disclose my health information: _____.

Please issue records by: ☐ CD ***or*** ☐ Paper

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

☐ Mail To Address Listed Above ☐ I will pick-up ☐ Office Fax Number/Attn:

_____

☐ *A Representative* will pick-up on my behalf (list name of *Representative*) _____

Mail Information to: ☐ Continued Medical Care ☐ Insurance ☐ Legal ☐ Other

Name/Address/Phone: _____

(Street, City, State _____

and Zip Code) _____

Marina Del Rey Hospital
A CEDARS-SINAI AFFILIATE

AUTHORIZATION TO USE AND RELEASE HEALTH INFORMATION

PATIENT ID

RI0050

TERM:
This Authorization will remain in effect:

☐ From the date of this Authorization until _____.

☐ Until MARINA DEL REY HOSPITAL fulfills this request.

☐ Until the following event occurs: _____

☐ Other: _____

PURPOSE:
I authorize MARINA DEL REY HOSPITAL to use of disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s): [Note: "at the request of the Patient" is sufficient if the Patient is initiating this Authorization]

☐ At the request of the patient ☐ Other _____.

I understand that once MARINA DEL REY HOSPITAL discloses my health information to the recipient, MARINA DEL REY HOSPITAL cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and California law governing the use and disclosure of my health information.

I understand MARINA DEL REY HOSPITAL may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at MARINA DEL REY HOSPITAL; except, however, if my treatment MARINA DEL REY HOSPITAL is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case MARINA DEL REY HOSPITAL may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to MARINA DEL REY HOSPITAL's Privacy Office. The revocation will be effective immediately upon MARINA DEL REY HOSPITAL's receipt of my written notice, except that the revocation will not have any effect on any action taken by MARINA DEL REY HOSPITAL in reliance on this Authorization before it received my written notice of revocation.

I may Contact MARINA DEL REY HOSPITAL's Privacy Office by mail at 4650 Lincoln Blvd., Marina Del Rey, CA 90292, by telephone at (310) 823-8911 ext. 5274.

I have read and understood the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize MARINA DEL REY HOSPITAL to use or disclose my health information in the manner described above.

_____ _____
Signature of Patient **Date**

Note: If the Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

_____ _____ _____
Signature of Authorized Personal Representative **Relationship to Patient** **Date**

FOR OFFICIAL USE ONLY: PROCESSED AND COMPLETED BY:

☐ HIM STAFF INITIALS _____ DATE _____

☐ NURSING/HOSPITAL STAFF INITIALS _____ DATE _____