AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient's Name:				
Last	First	M	iddle	
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				
		L 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☐ Psychotherapy Notes created by a mental☐ Information about HIV/AIDS-related test or reported, regardless of whether the rest	health professiting (including ults of such test	onal the fact that an HIV test v		
☐ Information about sexually transmitted di☐ Information about alcohol or drug abuse☐ Information about sexual assault☐ Information about child abuse and neglection.	treatment progr	am services		
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 Page 1 am requesting that the records identified about Mail To Address Listed Above I with the records identified about I will be a second of the r	ove be handled	Office Fax Number/Attr	1:	
☐ A Representative will pick-up on my beha Mail Information to: ☐ Continued Medical Name/Address/Phone: (Street, City, State	Care Ins	Representative)urance	Other	
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 a 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 expire 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			

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