

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization:

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**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/Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Mail  Patient will pick up  Family member will pick up Name: \_\_\_\_\_

**This authorization applies to the following:**

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

Only the following records or types of health information:

Service:  Inpatient  Outpatient  Emergency Date of Service: \_\_\_\_\_

ECU Records  Operative Report  MD Orders  Radiology Reports

History & Physical  Discharge Summary  Nurse's Notes  Anesthesia Records

Consults  MD Progress Notes  EKG, EMG, EEG  Lab/pathology Report

Other:

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

Alcohol/drug treatment information  HIV Test Results  Mental Health Treatment Information

**Purpose for Use/Disclose:**  Patient Request  Further Medical Care  Insurance **OR**

Other: \_\_\_\_\_

**Expiration:** This authorization expires (insert date or event): \_\_\_\_\_

**Notice Of Rights And Other Information:**

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to Hoag Hospital, Health Information Department, One Hoag Drive, Newport Beach, CA 92658. My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance on this authorization.
- I have a right to receive a copy of this authorization.
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
- I may inspect or obtain a copy of the health information that I am being asked to use or disclose

\_\_\_\_\_  
[Signature] [Date] [Time] A.M./P.M.

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

Witness: \_\_\_\_\_

AUTHORIZATION TO RELEASE COPIES OF MEDICAL RECORDS  
JIT 2363 Rev 06/20/03

Original - Chart

Copy - Patient



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MR #