TORRANCE MEMORIAL MEDICAL CENTER

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this document authorizes the 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.**

I hereby authorize **Torrance Memorial Medical Center** to use or disclose my protected health information as follows:

PATIENT IDENTIFICATION:

Patient Name:

Date of Birth:	** Phone number where we may contact you: ( )

** Note: ☐ O.K. to leave message with detailed information ☐ Leave message with call back number only

Please Choose One : ☐ I WOULD LIKE TO PICK UP ☐ PLEASE MAIL ☐ POWER CHART ACCESS *(for employees, please see note on page 2.)*

RELEASE TO: (One person/organization per form)

Persons / Organizations / Patient:
Name:

Address:

City, State, Zip: Phone no: ( )

I REQUEST COPIES OF MY MEDICAL RECORD:

☐ For my physician (no charge for copies) ☐ For my own use (Please see note)**

** Note: The law makes access conditional upon payment of allowable charges (25¢ per page)

TYPE OF INFORMATION TO BE RELEASED:

This authorization applies to the following information

Please select from the following:

☐ Doctor's Reports ☐ Emergency Room Reports

☐ Test Results ☐ Others _____

Specify the Date or Time Period for information selected:

From: _____ To: _____

_____ *(Please initial)* I understand that the information to be released may make reference to any drug, alcohol, psychiatric and/or mental health conditions.

EXPIRATION AND SIGNATURE:

This authorization is only valid for the above requested dates of service and expires one year from the date signed.

Signature: _____

***If patient is unable to sign, sign and state your legal relationship to the patient and present appropriate identification and/or documentation.*

Please check one :
☐ Patient ☐ Spouse
☐ Representative
☐ Other _____

Date:

Time:

Information released by : ☐ Administration ☐ HIM ☐ Radiology ☐ Laboratory ☐ Nurse ☐ Pharmacy **Initial and Date :**

ATTENTION EMPLOYEES: Please complete PAGE 2 upon release of record.

NOTICE OF RIGHTS AND OTHER INFORMATION:

- I may refuse to sign this Authorization. If you do, we will not be able to release your medical records to you or the requestor.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered or mailed to the:

  Health Information Management Department
  Torrance Memorial Medical Center
  3330 Lomita Blvd.
  Torrance, CA. 90505
- My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.
- I have a right to receive a copy of this authorization.
- Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide 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 required or permitted by law.
- I may inspect or obtain a copy of the protected health information that I am being asked to release.

REVOCATION OF REQUEST

☐ I would like to revoke this Authorization for Use or Disclosure of Protected Health Information request.

Signature: *(patient, representative, spouse)*	Date:	Time:
If signed by someone other than the patient, state your legal relationship to the patient:		
Torrance Memorial Medical Center Representative Signature:	Date:	Time:

OFFICE USE ONLY:

Records received by:	Date:	Time:
HIM Personnel Signature:	Date:	Time:

INFORMATION RELEASED:

I. Doctors Reports	**II. Test Results**	
☐ Discharge Summary ☐ H&P ☐ Operative Reports ☐ Consultation Reports ☐ ER Report (scanned) ☐ ER Dictated report ☐ Others _____	☐ Radiology report ☐ Labs ☐ EKG ☐ Pathology ☐ Others _____ **III.** ☐ **Complete records**	**NOTE :** For employees, this authorization expires upon separation from Torrance Memorial. For employees given the permission by a relative or by any other individual to have access to their medical record, this authorization expires one year from the date signed.