

**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:**

<b>Patient Name:</b> _____	
<b>Date of Birth:</b> _____	<b>** Phone number where we may contact you:</b> (    ) _____
** Note: <input type="checkbox"/> O.K. to leave message with detailed information <input type="checkbox"/> Leave message with call back number only	

**Please Choose:**

Method of delivery:    **PICK UP**     **MAIL**     **Patient Portal access**     **POWER CHART ACCESS**  
(for employees, please see note on page 2.)

Format:    **PAPER copy**     **ELECTRONIC copy (CD)**

**RELEASE TO: (One person/organization per form)**

<b>Persons / Organizations / Patient:</b> _____	
<b>Address:</b> _____	
<b>City, State, Zip:</b> _____	
<b>Email address:</b> _____	<b>Phone no:</b> (    ) _____

**I REQUEST COPIES OF MY MEDICAL RECORD:**

<input type="checkbox"/> <b>For my physician</b> (no charge for copies)	<input type="checkbox"/> <b>For my own use</b>
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**TYPE OF INFORMATION TO BE RELEASED:**

**This authorization applies to the following information**

**Please select from the following:**

**Doctor's Reports**     **Emergency Room Reports**     **Statement of Detailed Charges**  
 **Test Results**     **Other(s)** \_\_\_\_\_

**Specify the Date or Time Period for information selected:**

**From:** \_\_\_\_\_    **To:** \_\_\_\_\_



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

**EXPIRATION AND SIGNATURE:**

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

<b>Signature:</b> _____	<b>Please check one:</b> <input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Representative <input type="checkbox"/> Other _____	<b>Date:</b> _____
<small>**If patient is unable to sign, sign and state your legal relationship to the patient and present appropriate identification and/or documentation.</small>		<b>Time:</b> _____

Infor. released by :    Admin    HIM    Rad    Lab    Nurse    Pharm    Social Worker    BO   **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.

**REVOCAION OF REQUEST**

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

Signature: ( <i>patient, representative, spouse</i> )	Date:	Time:
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If signed by someone other than the patient, state your legal relationship to the patient:

Torrance Memorial Medical Center Representative Signature:	Date:	Time:
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**OFFICE USE ONLY:**

Records received by:	Date:	Time:
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HIM Personnel Signature:	Date:	Time:
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**INFORMATION RELEASED:**

<p><b>I. Doctors Reports</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Discharge Summary</li> <li><input type="checkbox"/> H&amp;P</li> <li><input type="checkbox"/> Operative Reports</li> <li><input type="checkbox"/> Consultation Reports</li> <li><input type="checkbox"/> ER Report (scanned)</li> <li><input type="checkbox"/> ER Dictated report</li> <li><input type="checkbox"/> Others _____</li> </ul>	<p><b>II. Test Results</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Radiology report</li> <li><input type="checkbox"/> Labs</li> <li><input type="checkbox"/> EKG</li> <li><input type="checkbox"/> Pathology</li> <li><input type="checkbox"/> Others _____</li> </ul> <p><b>III.</b> <input type="checkbox"/> <b>Billing records</b></p> <p><b>IV.</b> <input type="checkbox"/> <b>Complete records</b></p>	<p><b>NOTE :</b> For employees, this authorization expires upon separation from Torrance Memorial.</p> <p>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.</p>
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