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 disclosure my protected health information as follows:

PATIENT IDENTIFICATION:

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

Please Choose Method and Format:

☐ PICK UP OR ☐ MAIL ☐ PAPER copy OR ☐ ELECTRONIC copy (CD) ☐ 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 / ACCESS AS:

☐ For my physician (no charge)	☐ For my own use

TYPE OF INFORMATION TO BE RELEASED:

This Authorization applies to the following information:

☐ Copies of radiology images of tests. ☐ Copies of radiology reports of tests.

EXPIRATION AND SIGNATURE:

. **This authorization expires one year from the date signed.**	☐ I would like a copy of this authorization	
Signature:_____ ** If the 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:

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.

NOTICE OF RIGHTS AND OTHER INFORMATION:

TORRANCE MEMORIAL MEDICAL CENTER

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- 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 specifically 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 patient is unable to sign, sign and state your legal relationship to the patient and present appropriate identification and/or documentation:		
Torrance Memorial Medical Center Representative Signature:	Date:	Time:

OFFICE USE ONLY: I ACKNOWLEDGE RECEIPT OF IMAGES AND/OR TEST RESULTS

Records received by (patient name):	Date:
Mailed out (patient address):	Date:

Date(s) of service released, the content			**type and your name (PRINT):**		
Svc. Date	**Emp. Initial/ Date**	**Pat Int.**	**Svc. Date**	**Emp. Initial/ Date**	**Pat Int.**
CD _____	_____	_____	**CD** _____	_____	_____
Film _____	_____	_____	**Film** _____	_____	_____
Rpt _____	_____	_____	**Rpt** _____	_____	_____
Other _____	_____	_____	**Other** _____	_____	_____