AUTHORIZATION TO RELEASE MEDICAL INFORMATION

*** Indicates a REQUIRED field.**

Completion of this document authorizes the disclosure and use of health information about you.
Failure to provide all information requested may invalidate this authorization.

*Patient Name:_____ Medical Record #: _____

*Address: _____ *Date of Birth: _____

*City/State/Zip:_____ Telephone Number: _____

Please OBTAIN Information FROM:		Please SEND my medical information TO:	
*Name of Provider/Organization **Adventist Health Glendale**		*Name of Provider/Organization	
*Street Address **1509 Wilson Terrace**		*Street Address	
*City/State/Zip **Glendale, CA, 91206**		*City/State/Zip	
*Telephone Number	*Fax Number	*Telephone Number	*Fax Number
* Check delivery option	❑ Paper Copy ❑ CD (if available)	❑ Providers Fax # _____ ❑ E-Mail (encrypted) _____	

* What records do you want? (Check appropriate boxes below):

a. Date(s) of Service: _____/_____/_____ through _____/_____/_____

❑ Discharge Summary ❑ Emergency Room Records ❑ Operative/Procedure Reports ❑ Billing

❑ Test Results (X-Rays, Lab/Pathology Results) Please Specify:_____

❑Other (Immunization Records, Medication Lists) Please Specify:_____

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

❑ Mental health treatment information _____(initial) ❑ HIV test results _____(initial)

❑ Alcohol/drug treatment information _____(initial)

A separate authorization is required to authorize the disclosure or use of psychotherapy notes, as defined in the federal regulations implementing the Health Insurance Portability and Accountability Act.

* For the Purpose of: ❑ Patient Request ❑ Other: _____

PATIENT LABEL

Limitations, if any: _____
(Per CMIA-CA Medical Information Act-requires this authorization is to include both the specific uses and the limitations, if any, on the use of the medical information by the person(s) or entities authorized to receive the medical information.)

***Duration:** This authorization shall become valid upon signature and shall expire on _____
(Specify date, no longer than **one year** from date signed – required.)

- 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 inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: _____
- My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.
- Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may 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.

*Signature: _____
(Patient/Parent/Conservator/Guardian) Date/Time

If signed by other than patient, indicate relationship: _____

For Behavioral Health Records ONLY _____
(Signature of MINOR patient, if applicable) Date/Time

Witness:_____ Date:_____ Time: _____

I authorize _____ to pick up my medical records.

******FOR OFFICE USE ONLY******

❑ REQUEST COMPLETED - DATE:_____ _ PREPARED BY: _____
❑ IDENTITY OF INDIVIDUAL AND/OR LEGAL REPRESENTATIVE VERIFIED (STAFF INITIALS):_____
Notes: _____

Medical Records Release of Information Instructions

In order for your request to be valid and processed, please be sure to fill out all fields on the medical records release form and include a copy of the patient's picture identification

If you are requesting copies of your medical records, please note the following:

- There is a charge of $6.50 pre-payment plus 0.25 cents per page
- May take up to 14 working days to process
- We will need to make a copy of the requested patient's and the requestor's valid ID

If your request is for continuation of care, we can forward the copies to your health care provider at no charge. Please provide the complete name of physician and/or health care facility along with the mailing address, phone and fax number.

For radiology, cath lab images or billing, please contact the departments directly:

Glendale
Billing: 818-409-8200
Cath Lab: 818-863-4250
Radiology: 818-863-4185

Simi Valley
Billing: 805-955-6450
Cath Lab: 805-955-6560
Radiology: 805-955-6360

Adventist Health Glendale
Health Information Management
1509 Wilson Terrace
Glendale, CA 91206
818-409-8171
818-545-1872 fax

Adventist Health Simi Valley
Health Information Management
2975 Sycamore Drive
Simi Valley, CA 93065
805-955-6820
805-955-6824 fax