

STEP-BY-STEP INSTRUCTIONS TO COMPLETE THE REQUEST FOR RECORDS

Name and Date of Birth
of patient is needed



Patient Name: _____ Date of Birth: _____
I hereby authorize **Hoag Memorial Hospital Presbyterian, or its affiliates and affiliated providers** to
disclose the information listed below to: (List the person/organization authorized to receive this information.)

Name and Address of where you
want your records sent



Name/Organization: _____
Address: _____
City: _____ State: _____ Zip: _____ Phone: _____

Select the media type



Please select the type of format the records should be in:
☐ Paper ☐ CD ☐ USB

Now select how you would like to
receive the records



Please select how you would like to receive the records:
☐ Mail to the address above
☐ Patient will pick up
☐ I authorize _____ to pick up my medical record copies.

For electronic options, select one



Or you may receive the records electronically (please select):
☐ Secured Email: _____
☐ MyChart (patient portal)
☐ Secure Medical Image Exchange (Radiology/Cardiology images only): Email: _____

Dates(s) of service



This authorization applies to the following: Date(s) of Service: _____

Specific records requested (give
approximate date if unknown)



☐ ED/Urgent Care Records ☐ History & Physical ☐ Consults ☐ Operative Report
☐ Discharge Summary ☐ MD Notes ☐ MD Orders ☐ Nurse's Notes
☐ EKG, EMG, EEG ☐ Radiology Reports ☐ Anesthesia Records ☐ Lab/Pathology Reports
☐ Immunizations ☐ Radiology Images, Exam: _____
☐ Outpatient/Clinic Record – Clinic/Provider Name: _____
☐ Other: _____

Special consent to release sensitive
records. Check if applicable.



I specifically authorize release of the following information (check as appropriate):
☐ Substance Use Disorder treatment information ☐ HIV Test Results ☐ Abortion Related Services
☐ Mental Health Treatment Information ☐ Gender Affirmation Care

This is what you are using the
records for, what purpose



A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

Purpose for use/disclosure:
☐ Patient Request ☐ Further Medical Care ☐ Insurance **OR** ☐ Other: _____

How long you want this
authorization to last



Expiration:
This authorization will expire in 1 year from date of signature unless another date or event is specified:

****IMPORTANT** You MUST sign
your request – unsigned
requests cannot be processed.**



Patient/Legal Representative Signature: _____ **Date:** _____ **Time:** _____ **AM/PM**
If signed by other than patient, indicate legal relationship to patient: _____
Print Name (Legal Representative): _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
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Original – Chart

Copy – Patient