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/Organization: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Please select the type of format the records should be in:

☐ Paper ☐ CD ☐ USB

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.

Or you may receive the records electronically (please select):

☐ Secured Email: _____

☐ MyChart (patient portal)

☐ Secure Medical Image Exchange (Radiology/Cardiology images only): Email: _____

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

☐ 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: _____

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

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: _____

Expiration:

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

_____

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 COPIES OF MEDICAL RECORDS

Completion of this document authorizes the disclosure and/or 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:

Notice of Rights and Other Information:

- 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 revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to Hoag Hospital, Health Information Department, One Hoag Drive, Newport Beach, CA 92658. My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance on this authorization.
- I have a right to receive a copy of 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 patient health information from making further disclosure of it unless another authorization for such disclosure is obtained from the patient or authorized representative or unless such disclosure is specifically required or permitted by law.
- I may inspect or obtain a copy of the health information that I am being asked to allow the disclosure of.

Complete request information on reverse side...