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

Instructions		Form
Name and Date of Birth of patient is needed	→	Patient Name: ______________________________ Date of Birth: ______________ Social Security Number: ______ - _____ - __________
		Use of disclosure: I hereby authorize Hoag Memorial Hospital Presbyterian 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: ______________
Checking one of these boxes tells us how you want to receive the records	→	☐ Mail ☐ Patient will pick up ☐ Family member will pick up Name: ______________ Phone: ______________
		This authorization applies to the following:
All records/all dates of service	→	☐ All health information pertaining to any medical history, mental or physical condition and treatment received, **OR**
Specific records requested (give approximate date if unknown)	→	☐ Only the following records or types of health information: Date of Service: ______________ Service type: ☐ Inpatient ☐ Outpatient ☐ Emergency ☐ ECU Records ☐ History & Physical ☐ Consults ☐ Operative Report ☐ Discharge Summary ☐ MD Progress Notes ☐ MD Orders ☐ Nurse's Notes ☐ EKG, EMG, EEG ☐ Radiology Reports ☐ Anesthesia Records ☐ Lab/Pathology Reports ☐ Other: ______________________________
		I specifically authorize release of the following information (check as appropriate):
Special consent to release sensitive records. Check if applicable.	→	☐ Alcohol/drug treatment information ☐ HIV Test Results ☐ Mental Health Treatment Information A separate authorization is required to authorize disclosure or use of psychotherapy notes.
This is what you are using the records for what purpose	→	**Purpose for use/disclosure**: ☐ Patient Request ☐ Further Medical Care ☐ Insurance **OR** ☐ Other: ______________________________
How long you want this authorization to last	→	**Expiration**: This authorization expires (insert date or event): ______________________
****IMPORTANT ** You <u>MUST</u> sign your request – unsigned requests cannot be processed.**	→	______________________ [Signature] ____________ [Date] __________ [Time] A.M./P.M. If signed by other than patient, indicate legal relationship to patient: ______________________ Witness: ______________________