



**PERMISSION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)
to City of Hope National Medical Center (COHNMC)**

Last Name _____ First _____ Middle _____
 Address, City, State, Zip _____
 Preferred Telephone: (_____) _____ Date of Birth: ____/____/____

I am completing this form as the (*check one*):
 Patient Parent or Guardian of a Minor Patient
 Other (relationship to patient) - _____

PURPOSE: I authorize COHNMC to obtain my health information which I selected below for the following specific purpose: Continuity of Care.

DURATION: This Authorization will expire six (6) months from the date signed.

This authorization applies to the following information:

<input type="checkbox"/> Complete Health Record _____	<input type="checkbox"/> Outpatient Clinic Note(s) _____
<input type="checkbox"/> Chemotherapy Flowsheet(s) _____	<input type="checkbox"/> Pathology Report(s) _____
<input type="checkbox"/> Consultation Report(s) _____	<input type="checkbox"/> Pathology Slides/Block(s) _____
<input type="checkbox"/> Discharge Summary(ies) _____	<input type="checkbox"/> Radiology CD/Film(s) _____
<input type="checkbox"/> EKG(s) _____	<input type="checkbox"/> Radiology Report(s) _____
<input type="checkbox"/> History and Physical(s) _____	<input type="checkbox"/> Records brought to COHNMC _____
<input type="checkbox"/> Inpatient Rounds Note(s) _____	<input type="checkbox"/> Records from External Care Provider(s) _____
<input type="checkbox"/> Laboratory Report(s) _____	<input type="checkbox"/> Scan(s) _____
<input type="checkbox"/> Mental Health / Psychosocial Report(s) _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Operative Report(s) _____	_____

Date Needed by: _____

I authorize COHNMC to obtain my health information from:

Name of Facility _____ City and State _____

Name of Facility _____ City and State _____

Name of Facility _____ City and State _____

Name of Facility _____ City and State _____

PATIENT OR PERSONAL REPRESENTATIVE PRINTED NAME	SIGNATURE	DATE	TIME

If Personal Representative has signed above, please indicate your relationship to the patient:
 Parent Guardian Conservator Agent Other _____

<p>City of Hope National Medical Center 1500 East Duarte Road, Duarte, CA 91010</p> <p>Permission to Release Protected Health Information to City of Hope</p>	Patient Identification / Label: _____ Page 1 of 1 MRN _____ Patient Name _____ Date of Birth _____
	Form No. 8560-C017 PEPH Revised: 01-19-11 Original: Scanned into HIPAA-ROI Photocopy: Patient B: 02-10