



**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"/> History and Physical(s)	<input type="checkbox"/> Clinic Note(s)
<input type="checkbox"/> Discharge Summary(ies)	<input type="checkbox"/> Pathology Slides/Block(s), representative slides only, include any special studies
<input type="checkbox"/> Operative Report(s)	<input type="checkbox"/> Radiology CD/Film(s) including CT, MRI, PET and other films
<input type="checkbox"/> Pathology Report(s)	<input type="checkbox"/> Scan(s)
<input type="checkbox"/> Consultation Report(s)	<input type="checkbox"/> Chemotherapy Flowsheet(s)
<input type="checkbox"/> Radiology Report(s)	<input type="checkbox"/> Laboratory Report(s)
<input type="checkbox"/> Cardiology Reports (EKG/Echocardiogram)	<input type="checkbox"/> Other _____
<input type="checkbox"/> Pulmonary function reports	
<input type="checkbox"/> Neurology reports (EEG, EMG)	

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 _____

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

_____	_____
Print Name of Patient or Person Completing the Form	Date
_____	_____
Signature of Patient or Person Completing the Form	Date
Relationship to Patient: <input type="checkbox"/> Patient <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Guardian <input type="checkbox"/> Conservator <input type="checkbox"/> Other _____	

<p align="center">City of Hope National Medical Center 1500 East Duarte Road, Duarte, CA 91010</p> <p align="center">Permission to Release Protected Health Information to City of Hope</p>	Patient Identification/Label: _____ Page 1 of 1 MRN _____ Patient Name _____ Date of Birth _____
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