

I understand that COHNMC may deny this request under limited circumstances as provided under federal and state law protecting the privacy of health information. I further understand that, except as otherwise provided under applicable law, I have the right to authorize a review of certain of my records by a licensed physician or surgeon, licensed psychologist, licensed marriage and family therapist, or licensed clinical social worker designated by my written authorization.

I understand that COHNMC will notify me of its decision to approve or deny my request to inspect the Requested Information within five (5) working days of receiving this request. I understand that COHNMC will either deny my request to obtain a copy of the Requested Information or send me the copy within fifteen (15) calendar days of receiving this request. If I request a summary or explanation, COHNMC will try to complete it within ten (10) working days of receiving this request. However, COHNMC is unable to meet that deadline, COHNMC may extend the time up to a maximum of thirty (30) calendar days, by notifying me in writing of its need for additional time to comply.

If I am granted access to the Requested Information, I understand that City of Hope has entered into a partnership with Bactes Imaging Solutions to provide patients and their representatives with the reproduction and delivery of medical record copies, either on paper or on CD.

If I ask for physical or electronic copies of my medical records, Bactes will charge me:

- \$15.00 for the first 60 pages, and 25¢ per page thereafter for delivery within 15 days, and \$30.00 for RUSH orders for delivery within 2 to 5 days, for the copying services necessary to complete my request.

If I ask to receive the Requested Information in the form of a summary or explanation, City of Hope may charge me:

- The actual cost of preparing a summary or explanation, plus any applicable mailing fees.

TERM: This Authorization shall remain in effect for a maximum of six (6) months from the date of signature, or until the _____ day of _____, 20_____ .

PATIENT OR PERSONAL REPRESENTATIVE PRINTED NAME	SIGNATURE	DATE	TIME
IF PERSONAL REPRESENTATIVE HAS SIGNED ABOVE, INDICATE YOUR RELATIONSHIP TO THE PATIENT: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Conservator <input type="checkbox"/> Agent <input type="checkbox"/> Other		REASON PATIENT DID NOT SIGN	

Identity of Personal Representative verified via Photo ID Matching Signature Other, specify: _____

After you have completed this form, please return it by mail or by facsimile to the following address:

City of Hope National Medical Center
Health Information Management Services
Medical Record Correspondence Desk
 1500 East Duarte Road, Duarte, California 91010-3000
 Phone: 626-256-4673 ext. 62446 Fax: 626-301-8443
 Hours: Monday through Friday – 8:00 am to 4:30 pm