

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: ()		rth:/
I am completing this form as the (check one):	☐ Patient ☐ Parent or Guardi☐ Other (relationship to patient)	
PURPOSE: I authorize COHNMC to obtain my specific purpose: Continuity of Care	health information which I selected b	elow for the following
DURATION: This Authorization will expire six (6) months from the date signed.		
This authorization applies to the following information:		
□ Complete Health Record □ Chemotherapy Flowsheet(s) □ Consultation Report(s) □ Discharge Summary(ies) □ EKG(s) □ History and Physical(s) □ Inpatient Rounds Note(s) □ Laboratory Report(s) □ Mental Health / Psychosocial Report(s) □ Operative Report(s)	□ Pathology Report(s) □ Pathology Slides/Block(s □ Radiology CD/Film(s) □ Radiology Report(s) □ Records brought to COH □ Records from External Ca □ Scan(s) □ Other	NMCare Provider(s)
Date Needed by:		
I authorize COHNMC to obtain my health inform	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
Personal Representative must have legal guardianship or Power of Attorney to sign for patient. Please indicate your relationship to the patient: Parent □ Guardian □ Conservator □ Agent □ Other		
City of Hope National Medical Center 1500 East Duarte Road, Duarte, CA 91010 AFFIX PATIENT IDENTIFICATION LABEL HERE MRN		
Permission to Release Protected Health Information to City of Hope Patient Name		
Form No. 8560-C017 Revised: 01-10-13 PEPH	Original: HIPAA-ROI Photoco	ppy: Patient