City of Hope National Medical Center and/or City of Hope Medical Foundation ("COH")
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Release # (Staff Use):

Name: (Last)_____ (First)_____ (Middle)_____

DOB:_____ Address:_____ City/State/Zip Code _____

Preferred Telephone: (_____) _____-_____ ☐ Mobile ☐ Home ☐ Work ☐ Other

Email Address:_____

Purpose - I would like to: (Please check all that apply):

- ☐ Request a copy of my medical records for my healthcare provider
- ☐ Request my medical records for personal use
- ☐ Authorize COH to obtain my medical records from the specified provider(s) listed on page 2*
- ☐ Authorize COH to release my medical records / health information to the specified individual(s) listed on page 2*
- ☐ Other, Specify: _____

Please provide requested records in the following format: ☐ Paper Copy ☐ CD ☐ USB Drive
Delivery method: ☐ Pickup ☐ Mail ☐ Fax ☐ Secure Email **Date Needed By:**

Information To Be Released
Specify where services were rendered (Site Location, e.g. Duarte, Glendora, Pasadena):

_____

☐ Inpatient ☐ Outpatient Dates of Treatment: _____

☐ Pertinent Documents (H&P, Consult, Clinic Notes, Operative Report, Discharge Summary, Radiation Oncology, Chemotherapy & Test Results)

☐ Laboratory ☐ Pathology ☐ Pathology Slides ☐ Radiology ☐ Radiology Images ☐ Cardiology

☐ Genetic Testing Information

☐ Other, Specify: _____

MY HIGHLY CONFIDENTIAL INFORMATION: By checking the box(es) and placing my initials next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the type of highly confidential information indicated next to my initials, if any such information will be used or disclosed pursuant to this Authorization:

- ☐ _____ HIV/AIDS Testing or Treatment (including fact that an HIV test was ordered, performed or reported, regardless if whether the results of such tests were positive or negative)
- ☐ _____ Mental Illness or Developmental Disability Treatment
- ☐ _____ Substance Abuse Treatment (i.e. alcohol or drug)
- ☐ _____ Genetic Testing and Information

City of Hope
Authorization to Use and Disclose Protected Health Information

City of Hope National Medical Center and/or City of Hope Medical Foundation ("COH")
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

*PLEASE OBTAIN INFORMATION FROM, OR RELEASE MY INFORMATION TO:	
☐ Obtain From:	Name of Hospital/Clinic/Person: ______ Address/City/Zip Code: ______ Phone Number: ______ Fax Number: ______
☐ Release To:	Name of Hospital/Clinic/Person: ______ If releasing to a person, state relationship: ______ Address/City/Zip Code: ______ Phone Number: ______ Fax Number: ______ Email Address: ______
☐ Obtain From:	Name of Hospital/Clinic/Person: ______ Address/City/Zip Code: ______ Phone Number: ______ Fax Number: ______
☐ Release To:	Name of Hospital/Clinic/Person: ______ If releasing to a person, state relationship: ______ Address/City/Zip Code: ______ Phone Number: ______ Fax Number: ______ Email Address: ______
☐ Obtain From:	Name of Hospital/Clinic/Person: ______ Address/City/Zip Code: ______ Phone Number: ______ Fax Number: ______
☐ Release To:	Name of Hospital/Clinic/Person: ______ If releasing to a person, state relationship: ______ Address/City/Zip Code: ______ Phone Number: ______ Fax Number: ______ Email Address: ______

I understand that release or transfer of the disclosed information by COH to any person or entity not specified in this Authorization is prohibited by law. However, once COH discloses my health information to the recipient designated by me above, I understand that COH cannot guarantee that the recipient will not re-disclose my health information to a third party. I understand that the third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that COH 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.

City of Hope National Medical Center and/or City of Hope Medical Foundation ("COH")
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I understand that COH 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 COH 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. However, if COH is unable to meet that deadline, COH 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.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at COH, except, if my treatment at COH is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case COH may refuse to treat me if I do not sign this Authorization.

I have a right to receive a copy of this Authorization. I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to COH's Health Information Management Services (HIMS) at the address listed below. The revocation will be effective immediately upon COH's receipt of my written notice of revocation, except that the revocation will not have any effect on any action taken by COH in reliance on this Authorization before it received my written notice of revocation. If I have any questions about this Authorization, I may contact a Health Information Management Specialist during regular hours, Monday - Friday, 8:30 a.m. - 4:30 p.m. as follows:

City of Hope - Health Information Management Services
1500 E. Duarte Rd, Duarte, CA 91010-3000; Tel: (626) 218-2446; Fax: (626) 218-8443

PLEASE NOTE: All written reports will remain at COH as part of my permanent file, including records from external care providers. If I am granted access to the Requested Information, I understand that City of Hope has entered into a partnership with a copy service to provide patients and their representatives with the reproduction and delivery of medical record copies, either on paper or in digital format.

TERM: This Authorization shall remain in effect for a maximum of twelve (12) months from the date of signature.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below I hereby, knowingly and voluntarily, authorize COH to use or disclose my health information in the manner described above.

_____	_____	_____	_____
Printed Name of Patient (or Personal Representative)	*Signature of Patient (or Personal Representative)*	*Date*	*Time*

If the patient is a minor or is otherwise unable to sign this Authorization, please indicate the relationship of the Personal Representative to the Patient: ☐ Parent ☐ Guardian ☐ Conservator ☐ Agent ☐ Other, specify: _____

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

City of Hope
Authorization to Use and Disclose Protected Health Information