City of Hope ("COH")

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Release # (Staff Use):

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

Address:_____ City/State/Zip Code:_____

Date of Birth:_____Preferred Telephone: (____)_____ ☐ Mobile ☐ Home ☐ Work ☐ Other

Email _____

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
- ☐ Authorize COH to release my medical records / health information to the specified individual(s) listed on page 2*
- ☐ Other, Specify:_____

Information To Be Released

Specify where you received services: (Site Location, e.g. California, Illinois, Arizona, Georgia)

_____

☐ 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: _____

Please provide requested information in the following format(s):

☐ Paper Copy ☐ CD ☐ USB Drive ☐ FFPE Blocks ☐ H&E Slides

Delivery method: ☐ Mail ☐ Fax ☐ Secure Email **Date Needed By:**

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

If in IL or GA:

☐ _____ Infertility/IVF/Artificial Insemination

☐ _____ Child Abuse and Neglect

☐ _____ Sexual Assault

☐ _____ Abuse of an adult with disability

City of Hope

Authorization to Use and Disclose Protected Health Information

AFFIX PATIENT IDENTIFICATION LABEL HERE

MRN _____

Patient Name _____

Date of Birth _____

City of Hope ("COH")

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

***PLEASE OBTAIN INFORMATION FROM, OR RELEASE MY INFORMATION TO:**

☐ Obtain From: ☐ Release To:
Name of Hospital/Clinic/Person:______________________
Address/City/Zip Code: ______________________
Phone Number:__________ Fax Number:____________ Email Address:________________

☐ Obtain From: ☐ Release To:
Name of Hospital/Clinic/Person:______________________
Address/City/Zip Code: ______________________
Phone Number:__________ Fax Number:____________ Email Address:________________

☐ Obtain From: ☐ Release To:
Name of Hospital/Clinic/Person:______________________
Address/City/Zip Code: ______________________
Phone Number:__________ Fax Number:____________ Email Address:________________

☐ Obtain From: ☐ Release To:
Name of Hospital/Clinic/Person:______________________
Address/City/Zip Code: ______________________
Phone Number:__________ Fax Number:____________ Email Address:________________

☐ Obtain From: ☐ Release To:
Name of Hospital/Clinic/Person:______________________
Address/City/Zip Code: ______________________
Phone Number:__________ Fax Number:____________ Email Address:________________

☐ Obtain From: ☐ Release To:
Name of Hospital/Clinic/Person:______________________
Address/City/Zip Code: ______________________
Phone Number:__________ Fax Number:____________ Email Address:________________

City of Hope ("COH")
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

This authorization is valid for release of information for the dates listed on the request.

- I understand that COH may not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization.
- I understand that the use or disclosure of my health information is voluntary except in accordance with federal or state law and any mandatory reporting requirements.
- I understand that once my health information is disclosed it may be re-disclosed by the recipient and the information may not be protected by federal or state privacy laws or regulations.
- I understand that I have the right to inspect and copy the disclosed information.
- I understand that this authorization will expire twelve (12) months from the date signed on this form.This authorization may be revoked at any time by submitting a request in writing to the Health Information Management department; the revocation will not apply to any information already released.
- I understand that I may request a copy of this authorization form.

Please direct your request to:

COH - California

Email: himsroi@coh.org
Fax: (626) 218-8443, Attention: Health Information Management Services (ROI)
Mail: Health Information Management Services (ROI)
City of Hope
1500 East Duarte Road
Duarte, CA 91010

COH - Chicago, Atlanta, Phoenix, Hospitals and Outpatient Care Centers

Email: himsroi2@coh.org
Fax: (847) 746-6791, Attention: Health Information Management Services (ROI)
Mail: Health Information Management Services (ROI)
City of Hope
2520 Elisha Ave
Zion, IL 60099

City of Hope ("COH")

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

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*	*Tíme*

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: _____

LANGUAGE ASSISTANCE SERVICES ARE AVAILABLE

Amharic	ያስተውሉ፦ አማርኛ የሚናገሩ ከሆነ ለእርስዎ የሚሆን ነጻ የቋንቋ ድጋፍ አገልግሎት አለዎት። በ626-256-4674 ይደውሉ፣ ኤክስቴንሽን 62282
Arabic	تنبيه: إذا كنت تتحدث العربية، فيمكنك الحصول على خدمات المساعدة اللغوية المجانية إذا أردت ذلك. اتصل على 626-256-4674، الرقم الداخلي 62282
Armenian	ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե խոսում եք հայերեն, ապա Ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարե՛ք 626-256-4673, ext. 62282
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 626-256-4673，分機 62282
French	ATTENTION : si vous parlez français, des services d'aide linguistique gratuits sont à votre disposition. Appelez au 626-256-4674, poste 62282
French Creole	ATANSYON: Si w pale Fransè Kreyòl (Kreyòl Ayisyen), w ap jwenn sèvis asistans lengwistik gratis. Rele nan 626-256-4674, ekst. 62282
German	Achtung: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Rufen Sie 626-256-4674, Durchw. 62282 an.
Greek	ΠΡΟΣΟΧΗ: αν μιλάτε Ελληνικά, έχετε στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής βοήθειας. Καλέστε το 626-256-4674, εσωτ. γραμμή 62282
Gujarati	ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારા માટે નિ:શુલ્ક ભાષા સહાયતા સેવાઓ ઉપલબ્ધ છે. ફોન કરો: ૬૨૬-૨૫૬-૪૬૭૪, એક્સટેન્શન. ૬૨૨૮૨
Hindi	कृपया ध्यान दें: यदि आप हिंदी बोलते हैं तो भाषा सहायता सेवा आपके लिए मुफ्त में उपलब्ध हैं। सेवा के लिए 626-256-4673, विस्तार 62282 पर फोन करें
Hmong	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 626-256-4673, ext. 62282
Italian	ATTENZIONE: se parli italiano, hai a tua disposizione servizi di assistenza linguistica gratuiti. Chiama il 626-256-4674, int. 62282
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます（626-256-4673、内線：62282）。
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 626-256-4673, ext. 62282 번으로 전화해 주십시오
Mon-Khmer, Cambodian	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃ គឺអាចមានផ្តល់ជូនសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 626-256-4673, ext. 62282
Navajo	Da' íísinołts'ą́ą': Diné Bizaad bee yánłti'go, t'áájí k'eh nika' adoolwołígíí hóló. Kwijį' hwidiílnih, 626-256-4674, ext. 62282
Panjabi	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਫ਼ੈਸਲੇ ਦੌਰਾਨ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਵਿੱਚ ਭਾਸ਼ਾ ਸੰਬੰਧੀ ਸਹਾਇਤਾ ਸੇਵਾ ਉਪਲਬਧ ਹੈ। ਕਾਲ ਕਰੋ: 626-256-4673, ਐਕਸਟੈਂਸ਼ਨ 62282
Persian	توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در اختیارتان قرار دارد. تلفن تماس: 626-256-4673، تلفن داخلی: 62282

City of Hope

LANGUAGE ASSISTANCE SERVICES

AFFIX PATIENT IDENTIFICATION LABEL HERE

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LANGUAGE ASSISTANCE SERVICES ARE AVAILABLE

Polish	UWAGA: Jeśli posługujesz się językiem polskim, możesz skorzystać z bezpłatnego wsparcia językowego. Prosimy o kontakt pod numerem 626-256-4674, wew. 62282
Portuguese	ATENÇÃO: se você fala português, há serviços gratuitos de assistência linguística à sua disposição. Ligue para 626-256-4674, ramal 62282
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 626-256-4673, ext. 62282
Serbo-Croatian	POZOR: ako govorite hrvatski, na raspolaganju su vam besplatne usluge jezične podrške. Nazovite 626-256-4674, int. 62282
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 626-256-4674, ext. 62282
Syriac	[illegible] 626-256-4674 [illegible] ،62282.
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 626-256-4673, ext. 62282
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 626-256-4673 ต่อ 62282
Urdu	دھیان دیں: اگر آپ اردو بولتے ہیں تو آپ کے لیے کسی بھی وقت زبان کی معاونت کی خدمات مفت دستیاب ہیں۔ ایکسٹینشن 62282 پر کال کریں، 626-256-4674
Vietnamese	CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số 626-256-4673, máy lẻ 62282

City of Hope

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