Memorial Hospital of Gardena

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Information	Patient Name		AKA/Maiden Name/Other	
	Address		City/State/Zip Code	
	Date of Birth	Phone	Email Address	
	/ /			

Information to be Released From:	Facility Name	Address	Phone #	Fax #
	Memorial Hospital of Gardena	1145 W. Redondo Beach Blvd., Gardena, CA 90247	310-532-4200 Ext. 7285	310-538-6699

Information to be Released to:	Name of Hospital/Clinic/Physician/Person	
	Street Address	City/State/Zip Code
	Phone	Fax (Urgent patient care)

For What Purpose:

__ Continuation of Care __ Personal Use
__ Insurance __ Legal __ Disability
__ Other (please specify): _____

Information to be Released:

Dates of Service: From_____ To_____

__History & Physical	__Discharge Summary
__Consultation Report	__Operative Report
__Pathology Report	__Radiology Report
__Emergency Department	__Laboratory Report/Result
__EKG Report	__Physician Progress Note
__Physician Order	__Nurses Note
__Medication Report	__Mental Health Evaluation
__Records for Continuity of Care	__Records for Personal Use
__Other_____	__Other_____

State/Federal laws require specific authorization to release the following types of Protected Health Information:

_____ Mental Health/Psychiatric Treatment _____ Genetic Testing

_____Alcohol/Drug Abuse Treatment _____HIV/AIDS Test Results

Please initial the line next to the information you are authorizing for release

PATIENT LABEL
Hospital & Clinic Staff:
Affix a patient label here if providing records to the patient.

Memorial Hospital of Gardena

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Authorization	• I understand that the completion and signing of this authorization is voluntary. • I understand that a photocopy of this authorization will be considered as valid as the original. • I understand that treatment, payment, enrollment or eligibility will not be conditioned upon my signing this authorization. • I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. • I understand this authorization may be revoked in writing at any time except to the extent that action had been taken in reliance on this authorization. • To revoke this authorization, I must do so in writing and it must be sent to the facility I have authorized my information to be released from. • Unless otherwise revoked, this authorization will expire 180 days after the date of signing this form. • I understand that I have a right to receive a copy of this authorization. • I understand that a separate, specific authorization is required to authorize the disclosure or use of psychotherapy notes, as defined in the federal regulations implementing the Health Insurance Portability and Accountability Act.

I understand that there may be a fee associated with this request.

	__Paper Records delivered by __ Mail __ Fax __Pickup at the Facility Date:_____ __Records in Electronic Format __CD __I do want my records encrypted __I do Not want my records encrypted

_____	_____	_____	_____ AM or PM
Signature of Patient or Authorized Representative	Printed Name	Date	Time
_____	_____	_____	_____ AM or PM
Relationship (if signed by other than patient)	Printed Name	Date	Time

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