AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Failure to provide all information may invalidate this authorization

Authorization for copies of medical record: ❑ Paper ❑ Electronic

❑ Other: _____ ❑ Inspect or review medical record

Patient Information

Patient name (first, middle, last) (please print): _____

MRN: _____ Date of birth (MM/DD/YYYY): _____ Phone: _____

Street address: _____

City: _____ State: _____ ZIP code: _____

Information to Release to/Request from

I authorize Cedars-Sinai to release/request medical records.

❑ Release to: _____

❑ Request from: _____

Person/Organization: _____

Street address: _____

City: _____ State: _____ ZIP code: _____

Phone: _____ Fax: _____

For the following purpose:

❑ Continuing care ❑ Insurance ❑ Legal

❑ Personal use ❑ Other (please specify): _____

Information to Release

Treatment dates: _____

❑ History and physical report ❑ Radiology report ❑ X-ray film/Images CD

❑ EKG/ECHO ❑ Operative report ❑ Laboratory report

❑ Discharge summary ❑ Consultation report ❑ Emergency record

❑ Pathology report ❑ Billing record

❑ Other (please specify): _____

❑ Outpatient/Clinic record - Clinic/Provider name: _____

Information to Release (continued)

State/Federal laws require specific authorization to release the following types of information:

❑ Mental health ❑ Alcohol/Drug abuse ❑ HIV test results

A separate authorization is required for psychotherapy notes.

Fees

Based on California Evidence Code Sections 1560-1567 Fees may be charged for medical record copies.

Delivery Instructions

❑ Mail records directly to person or organization specified

❑ Call requestor when records are ready for pickup:

I authorize (please print name) _____ to pick up my medical record copies.

Relationship to patient (please print): _____

❑ My CS-Link™ (patient portal)

❑ Email: _____

❑ Other: _____

Notice of Rights

I understand that:

1. If I refuse to sign this authorization my refusal will not affect my ability to obtain treatment.
2. I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
3. I may revoke this authorization at any time in writing, **signed by me or on my behalf and delivered to:**
   Cedars-Sinai Medical Center, Health Information Department
   8700 Beverly Blvd., Room 2901
   Los Angeles, CA 90048
4. If I revoke this authorization, the revocation will not have any effect on any actions taken prior to receiving the revocation.
5. I have a right to receive a copy of this authorization.

Notice of Rights (continued)

6. Information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

7. If this ❑ is checked, the requester will receive compensation for the use or disclosure of my information.

Expiration

Without my written revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 180 days from the date hereof, unless otherwise specified:

_____

_____

Signature (Patient, Power of Attorney for Healthcare or Legal Representative)

_____ _____

Date (MM/DD/YYYY) Legal representative relationship:

Health Information Management Department
8700 Beverly Blvd., Room 2901, Los Angeles, CA 90048
Email: GroupHIDInternetInquiries@cshs.org
Phone: 310-423-2259 • Fax: 310-423-0113