

Section A: Patient Identification (Required)

Patient Name:	Sex:	Date of Birth:	Social Security Number
Address		Telephone Number:	
If requested by Personal/Legal Representative (Name & Relationship):			

Section B: Request for Inspection and/or Copying of Your Health Information

You have a right to inspect and obtain a copy of your health information for as long as we maintain the information in our records, with certain limited exceptions. To submit a request, please fill in the following information:

Indicate preference: I will visit the hospital to inspect the records
 I will pick-up the copies requested
 Please mail the copies I requested to the address above

Under certain limited circumstances, we may deny your request to inspect and/or copy your health information. If access is denied, you may request that the denial be reviewed. Instructions for the review process will be included with any denial.

There are fees associated with copying and mailing of records.

Section C: Authorization for Disclosure of Health Information (Complete only if the disclosure is to Someone Other Than You or Your Personal/Legal Representative)

I hereby authorize Mission Hospital (MH) CHOC at Mission (CHM) to release a copy of my health information to the person/organization specified below:

Will pick-up or Mail to:

Person/Agency/Organization:	Address:
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1. I understand that I may refuse to sign this authorization and that MH and CHM may not condition my treatment upon whether I sign this authorization. I understand that if I have authorized the disclosure of information to someone who is not legally required to keep it confidential, the recipient may re-disclose it, and it may no longer be protected.
2. I understand that this authorization is effective immediately and will remain in effect until _____ (specify date, but no longer than six months from the date of this authorization). I understand that I have a right to receive a copy of this authorization. I reserve the right to withdraw or revoke this authorization, in writing at any time, except to the extent that MH or CHM has already disclosed the information.
 To withdraw or revoke this authorization, submit written request to Medical Records.

**AUTHORIZATION FOR DISCLOSURE OF
 HEALTH INFORMATION**

PATIENT I.D. AREA – Do not write in this space

- Address: 27700 Medical Center Road, Mission Viejo, CA 92691
- Contact (949) 364-7724 ext. 2230 for more information and instructions

Section D: Health Information to be Accessed or Disclosed (To be completed by all requestors)

1. Access and/or disclosure shall be limited to the following elements of my health information:

Medical Records:

- | | | |
|---|--|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Immunization Record |
| <input type="checkbox"/> Inpatient Progress Notes | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Consultation Report |
| <input type="checkbox"/> Emergency Room Record | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Radiology (X-ray) Report |
| <input type="checkbox"/> Outpatient Notes | <input type="checkbox"/> Laboratory Test Reports | |

Other Records:

- Radiology Film/Image [*Request will be forwarded to the Film Library for processing. If you have any questions, please call (949) 364-7709*]
- Billing Records [*Request will be forwarded to the Billing Department for processing. If you have any questions, please call (949) 365-2197*]
- Other (Specify): _____

2. Such access or disclosure is limited to the following:

- Type of information (specific medical condition): _____
- From (date) _____ to (date) _____

3. To access or disclose any of the following restricted information, initial the appropriate box(es):

- _____ HIV Test Result _____ Alcohol/Drug Abuse
 _____ Psychiatric/Mental Health (additional internal approval required)

4. The purpose of the requested access or disclosure: Patient Request Other: _____

Signature: _____ Date: _____

If signed by other than patient, indicate relationship: _____

If interpreted: _____

Interpreter Signature

Print Name

Language

Date

Time

Position/Relationship to Patient

FOR HOSPITAL STAFF USE ONLY (Checklist of Documents Released)

- | | | |
|--|--|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Laboratory Report | Restricted Information: |
| <input type="checkbox"/> H&P/Progress Notes | <input type="checkbox"/> X-Ray Report/Film | <input type="checkbox"/> Psychiatric/Mental Health |
| <input type="checkbox"/> Emergency Room Record | <input type="checkbox"/> Immunization Record | <input type="checkbox"/> HIV Test Result |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Outpatient Notes | <input type="checkbox"/> Alcohol/Drug Abuse |
| <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Billing Records | |
| <input type="checkbox"/> Consultation Report | <input type="checkbox"/> Other (Specify) _____ | |

Processed by: _____

Date: _____

**AUTHORIZATION FOR DISCLOSURE OF
HEALTH INFORMATION**

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