OLYMPIA MEDICAL CENTER
An Alecto Healthcare Hospital

MR #: _____

Visit #: _____

AUTHORIZATION for RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Authorization for: Copies of Medical Record ❑ Paper ❑ Electronic ❑ Other

❑ Inspect or Review Medical Record

Patient Information

Patient Name: _____ SSN – Last Four Digits: _____
(Last Name) (First Name)

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Release To Request From

I authorize Olympia Medical Center to Release / Request Medical Records Release To: ❑ Request From: ❑

Person/Organization: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Purpose

For the following:

___Continuing Care

___Insurance

___Legal

___Personal Use

___Other: _____

Information to Release

Treatment Dates: _____

____ Pertinent Health Records:

____ Face Sheet
____ Emergency Record
____ History and Physical Report
____ Discharge Summary
____ Consultation Report
____ Radiology Report
____ Operative Report
____ Laboratory Report
____ Pathology Report
____ Cardiology Report
____ Other (Please Specify): _____

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

____ Mental Health
____ HIV Test Results
____ Alcohol / Drug Abuse

Fees

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

Delivery Instructions

Request Delivery: ❑ CD ❑ Fax ❑ Paper Copy

❑ Mail Records directly to person or organization specified

❑ Call Requestor when records are ready for pick up

I authorize _____ to pick up my medical record copies.

Relationship to patient: _____

Other: _____

Notice of Rights

1. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing, sign by me or on my behalf and delivered to the **Health Information Management Dept. at Olympia Medical Center, 5900 W. Olympic Blvd., Los Angeles, CA 90036.**
2. I understand that the revocation will not apply to information that has already released in responses to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
3. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not 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.
4. I understand I have a right to receive a copy of this authorization after signing. I understand that Olympia Medical Center will either, within five (5) days for a request to inspect and fifteen (15) days for a request, grant the request or provide me with a written denial of the request that states the basis for the denial.
5. If I have questions about disclosure of my health information, I can contact **Release of Information at 323-932-5275, 323-932-5002, 323-932-5259**; or the HIM Director/Privacy Officer at 323-932-5003.

Term

Unless otherwise revoked, this authorization will automatically expire six months (180 days) from the date of a signature.

Signature

Signature of Patient: _____ Date: _____

If patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

Signature of Legal Representative: _____ Date: _____

Medical Records Department OPEN Monday – Friday from 8:00AM to 4:00PM