EAST LOS ANGELES DOCTORS HOSPITAL

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 #
	East Los Angeles Doctors Hospital	4060 E Whittier Blvd Los Angeles, CA 90023	323-268-5514 Ext. 4128	323-260-4277

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

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

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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