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 Whittier Blvd. Los Angeles, CA 90023	(323) 268-5514	(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 __ Insurance __ Legal __ Other (please specify): _____		__ Personal Use __ Disability	
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.

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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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