☐ Hoag Memorial Hospital Presbyterian Newport Beach ☐ Hoag Irvine ☐ Hoag Medical Group ☐ Hoag Urgent Care
☐ Hoag Physician Partners ☐ Hoag Concierge Medicine ☐ Hoag Specialty Clinic ☐ Hoag Orthopedic Institute

Patient Name: _____ Date of Birth: _____

Use of disclosure: I hereby authorize Hoag Memorial Hospital Presbyterian, or the Hoag entity selected above and affiliates to disclose the information listed below to: (List the person/organization authorized to receive this information.)

Name/Organization: _____
Address: _____
City: _____ State: _____ Zip: _____ Phone: _____

Media: ☐ Paper ☐ CD ☐ USB
How to receive: ☐ Mail ☐ Patient will pick up
☐ Authorized Representative will pick up:
Name: _____ Phone: _____
Electronic Option: ☐ Secured Email: _____
☐ MyChart (services on or after 4/28/18)
☐ Secure Medical Image Exchange (Radiology/Cardiology images only)
Email: _____

This authorization applies to the following:

☐ Only the following records or types of health information: Date of Service: _____

☐ ED Records	☐ History & Physical	☐ Consults	☐ Operative Report
☐ Discharge Summary	☐ MD Progress Notes	☐ MD Orders	☐ Nurse's Notes
☐ EKG, EMG, EEG	☐ Radiology Reports	☐ Anesthesia Records	☐ Lab/Pathology Reports
☐ Immunizations	☐ Radiology Images, Exam: _____		☐ Other: _____

I specifically authorize release of the following information (check as appropriate):

☐ Alcohol/drug treatment information ☐ HIV Test Results ☐ Mental Health Treatment Information

A separate authorization is required to authorize the disclosure or use of psychotherapy notes, as defined in the federal regulations implementing the Health Insurance Portability Accountability Acct (HIPAA).

Purpose for use/disclosure:

☐ Patient Request ☐ Further Medical Care ☐ Insurance **OR** ☐ Other: _____

Expiration:

This authorization will expire in 1 year from date of signature unless another date is specified: _____

Signature: _____ Date: _____ Time: _____AM/PM
[Patient/Legal Representative]

If signed by other than patient, indicate legal relationship to patient: _____

Print Name (Legal Representative): _____

California Hospital Association (03/13)

MR Processed by: _____ Date: _____ Time: _____ AM/PM
Radiology Processed by: _____ Date: _____ Time: _____ AM/PM

AUTHORIZATION TO RELEASE COPIES OF MEDICAL RECORDS

Dear Patient:

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization:

Notice of Rights and Other Information:

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to Hoag Hospital, Health Information Department, One Hoag Drive, Newport Beach, CA 92658. My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance on this authorization.
- I have a right to receive a copy of this authorization.
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might 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.
- I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

Complete request information on reverse side...