



CEDARS-SINAI MEDICAL CENTER.

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Failure to provide all information may invalidate this authorization

Authorization for: Copies of Medical Record Inspect or Review Medical Record

Patient Information	Patient Name: _____ (Last Name) (First Name) MRN: _____ Date of Birth: _____ Phone: _____ Address: _____ City: _____ State: _____ Zip: _____		
Release To	I authorize Cedars-Sinai to Release Medical Records to: Person / Organization: _____ Address: _____ City/State/Zip: _____ Phone: _____ Fax: _____	Purpose	For the following: <input type="checkbox"/> Continuing Care <input type="checkbox"/> Insurance <input type="checkbox"/> Legal <input type="checkbox"/> Personal Use <input type="checkbox"/> Other: _____
Information to Release	Treatment Dates: _____ <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Emergency Record <input type="checkbox"/> Operative Report <input type="checkbox"/> Billing Record <input type="checkbox"/> Laboratory Report <input type="checkbox"/> EKG <input type="checkbox"/> Pathology Report <input type="checkbox"/> Radiology Report <input type="checkbox"/> Consultation Report <input type="checkbox"/> Xray Film/Images CD <input type="checkbox"/> Other (<i>Please Specify</i>) _____ <input type="checkbox"/> Outpatient / Clinic Record - Clinic / Provider Name: _____ State / Federal Laws require specific authorization to release the following types of information: <input type="checkbox"/> Mental Health <input type="checkbox"/> HIV test results <input type="checkbox"/> Alcohol / Drug Abuse	Fees	<p align="center">Based on California Evidence Code Sections 1560-1567 Fees may be charged for medical record copies.</p>
A separate authorization is required for psychotherapy notes.			

Delivery Instructions	<input type="checkbox"/> Mail records directly to person or organization specified <input type="checkbox"/> Call Requestor when records are ready for pick up I authorize _____ to pick up my medical record copies. Relationship to patient: _____ <input type="checkbox"/> Other: _____
Notice of Rights	I understand that: <ol style="list-style-type: none"> 1. If I refuse to sign this authorization my refusal will not affect my ability to obtain treatment. 2. I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of. 3. I may revoke this authorization at any time in writing, <u>signed by me or on my behalf and delivered to Cedars-Sinai Medical Center, Health Information Department, 8700 Beverly Blvd., Room 2901, Los Angeles, CA 90048.</u> 4. If I revoke this authorization, the revocation will not have any effect on any actions taken prior to receiving the revocation. 5. I have a right to receive a copy of this authorization. 6. Information disclosed pursuant to this authorization could be re-disclosed by the recipient and may 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. 7. If this <input type="checkbox"/> is checked, the Requestor will receive compensation for the use or disclosure of my information.
Expiration	Without my written revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 180 days from the date hereof, unless otherwise specified: _____
Signature	Signature: _____ (Patient or Legal Representative) Date: _____ Legal Representative Relationship: _____

**Cedars-Sinai Medical Center, Health Information Management Department
8700 Beverly Blvd., Room 2901, Los Angeles, CA 90048**