Garfield Medical Center
AHMC Healthcare

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Failure to provide all information may invalidate this authorization

Medical Record Number: _____

Authorization for: Copies of Medical Record ☐ **Paper** ☐ **Electronic** ☐ **Other**

☐ **Inspect or Review Medical Record**

PATIENT INFORMATION

Patient Name: _____ (Last Name)	(First Name)	(Middle Initial)
Date of Birth:	Phone Number:	
Address:		
City:	State:	Zip code:

RELEASE TO

I authorize Garfield Medical Center to Release Medical records to:

Person / Organization:		
Address:		
City:	State:	Zip code:
Phone Number:	Fax Number:	

PURPOSE

	Continuing Care		Insurance
	Legal		Personal Use
	Other	Please specify:	

INFORMATION TO BE RELEASED

Date(s)of Treatment:

Please check all that apply

Based on California Health and Safety Code Section 123100-123149.5 and Evidence Code Section 1560-1567 fees may be charged for medical record copies.		History and Physical			Discharge Summary
		Emergency Record			Operative Report
		Consultation Report			Laboratory Report
		EKG/ECHO		CD	Pathology Report
		Radiology Report			Radiology Films/CD
		ALL RECORDS			Pertinent Records
		Other	Please specify:		

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

		Mental Health		HIV Test Results
		Alcohol/Drug Abuse		

A separate authorization is required for psychotherapy notes.

FOR INTERNAL USE ONLY: Check box if permanent transfer done ☐

525 N Garfield Avenue, Monterey Park, CA 91754
Phone: (626) 307-2100 Fax: (626) 307-2186

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DELIVERY INSTRUCTIONS

☐	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:	
☐	Hand-carried	
☐	E-Mail	Email Address:
☐	Other	Please specify:

NOTICE OF RIGHTS

I understand that:

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, signed by me or on my behalf and mailed to Garfield Medical Center's Privacy Officer, 525 N. Garfield Ave. Monterey Park, CA 91754.
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 the right to receive a copy of this authorization. I want to receive a copy of this authorization ☐ **Yes** ☐ **No** **Initials**: _____
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. I understand that the Compact Disc (CD) to be released contains a copy of my medical images. I hereby release Garfield Medical Center and its agents and employees from all liability that may arise from the release of the Compact Disc (CD).

TERM

Without 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:	**Date:**
(Patient, Power of Attorney for Healthcare or Legal Representative)	
Legal Representative Relationship:	