San Gabriel Valley Medical Center
AHMC Healthcare

Requesting your medical records:

Your request for medical records will be processed as follows:

- ✓ Complete all sections (1-7) of the Authorization Form
- ✓ Turn in form to HIM via:
  - Email: SGVMCportal@ahmchealth.com
  - Mail: 438 W Las Tunas Drive, San Gabriel CA 91776
  - Fax: (626) 457-4791
- ✓ Provide a copy of your ID or Passport
- ✓ Provide correct contact information such as a valid phone number so we can contact you if we have any questions
- ✓ Only the patient, unless the patient is a minor, can sign the authorization form. If you are requesting records for someone else, you will need to furnish a power of attorney, conservatorship document or contact HIM for assistance.

Delivery Options

You can choose to have your records mailed, emailed, faxed or picked up.
For pick-up we will contact you once records are ready.

Processing Time and fees

Requests for pertinent information will be processed as soon as possible, but can take up to seven (7) business days to complete.

Requests for specific reports or pertinent records are free of charge.

Requests for **ALL RECORDS** will be processed by our copy service (CIOX) and there will be cost-based fees associated with request of all medical records.

- Electronic records being provided in an electronic format (CD, e-delivery): $6.50 plus tax and shipping if applicable
- Printed copy: $0.05 per page
- If records need to be scanned, additional $.07 per page for the scanned portion

Processing time is 5-7 business days. Payment will be invoiced.

Questions or to Follow-up

Health Information Management
Tel: (626) 570-6630, Fax: (626) 457-4791
Monday – Friday: 8:00am – 4:00pm

San Gabriel Valley Medical Center
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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Failure to provide all information may invalidate this authorization

Authorization for: Copies of Medical Record ❑ Paper ❑ Electronic ❑ Other _____
❑ Inspect or Review Medical Record

1. Patient Information

Patient Name: _____ MRN: _____
(Last Name) (First Name)
Date of Birth: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip: _____

2. Release To Request From

I authorize San Gabriel Valley Medical Center to Release /Request Medical Records

Release To: ❑
Request From: ❑
Person / Organization: _____
Address: _____
City / State / Zip: _____
Phone: _____ Fax: _____

3. Purpose

For the following:

___ Continuing Care
___ Insurance
___ Legal
___ Personal Use
___ Other: _____

4. Information to Release

Treatment Dates: _____

___ History and Physical Report
___ Emergency Record
___ EKG/ECHO
___ Radiology Report
___ Radiology Images CD
___ Other (*Please Specify*) _____
___ Discharge Summary
___ Operative Report
___ Laboratory Report
___ Pathology Report
___ Consultation Report

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

___ Mental Health (other than psychotherapy notes*)
___ HIV test results
___ Alcohol / Drug Abuse

*A separate authorization is required for psychotherapy notes.

Fees

Fees may be charged as provided by applicable laws and regulations.

5. 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 to patient: _____

- ❑ Patient Portal
- ❑ E-mail: _____
- ❑ Other: _____

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; subject, however, to very limited exceptions as provided under law.
3. I may revoke this authorization at any time in writing, signed by me or on my behalf and delivered to: San Gabriel Valley Medical Center, HIM Department, 438 W. Las Tunas Dr., San Gabriel CA, 91776
4. If I revoke this authorization, the revocation will not have any effect on any actions taken in reliance on this authorization 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.

6. Expiration

Unless otherwise revoked, this authorization will automatically expire_____ (insert date or event). If no date or event is indicated, this authorization will expire 180 days from the date hereof.

7. Signature

Signature:_____Date: _____

(Patient, Power of Attorney for Healthcare or Legal Representative)

Legal Representative Name and Relationship: _____