



**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 #
	Community Hospital of Huntington Park	2623 E. Slauson Ave. Huntington Park, CA 90255	323-583-1931 Ext. 6630	323-589-5288
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:	<input type="checkbox"/> Continuation of Care <input type="checkbox"/> Insurance <input type="checkbox"/> Other (please specify): _____		<input type="checkbox"/> Personal Use <input type="checkbox"/> Legal <input type="checkbox"/> Disability	
Information to be Released:	Dates of Service: From _____ To _____			
	<input type="checkbox"/> History & Physical <input type="checkbox"/> Consultation Report <input type="checkbox"/> Pathology Report <input type="checkbox"/> Emergency Department <input type="checkbox"/> EKG Report <input type="checkbox"/> Physician Order <input type="checkbox"/> Medication Report <input type="checkbox"/> Records for Continuity of Care <input type="checkbox"/> Other _____	<input type="checkbox"/> Discharge Summary <input type="checkbox"/> Operative Report <input type="checkbox"/> Radiology Report <input type="checkbox"/> Laboratory Report/Result <input type="checkbox"/> Physician Progress Note <input type="checkbox"/> Nurses Note <input type="checkbox"/> Mental Health Evaluation <input type="checkbox"/> Records for Personal Use <input type="checkbox"/> 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



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Authorization	<ul style="list-style-type: none"> • 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.
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I understand that there may be a fee associated with this request.

<input type="checkbox"/> Paper Records delivered by <input type="checkbox"/> Pickup at the Facility <input type="checkbox"/> Records in Electronic Format <input type="checkbox"/> I do want my records encrypted <input type="checkbox"/> I do Not want my records encrypted	<input type="checkbox"/> Mail <input type="checkbox"/> Fax Date: _____ <input type="checkbox"/> CD
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_____	_____	_____	_____	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	

PATIENT LABEL
 Hospital & Clinic Staff:
 Affix a patient label here if
 providing records to the patient.