CITY OF HOPE ("COH")

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Today's Date _____

Name: (Last) _____ (First) _____ (Middle) _____

Address: _____ City/State _____ Zip Code _____

Preferred Telephone: (_____) _____ Date of Birth: _____ / _____ / _____

I am completing this form as the *(check one)*: ☐ Patient ☐ Parent or Guardian of Minor Patient
☐ Other (relationship to patient) -

Date Needed By:

I would like to (Please check all that apply):
☐ Request a copy of the medical records for a second opinion.
☐ Request a copy of the medical records be sent to another provider or entity.
☐ Request for medical records from another provider be sent to:
☐ COH Duarte ☐ COH Antelope Valley ☐ COH South Pasadena ☐ COH Santa Clarita

This authorization applies to the following information: (Specify information requested by checking boxes below. If information released should be limited to a particular date(s) of services, please insert date(s) of service next to item(s) chosen. If no date(s) are provided, all information within the checked category will be released.)

☐ Complete Health Record _____
☐ Chemotherapy Flowsheet(s) _____
☐ Consultation Report(s)_____
☐ Discharge Summary(ies) _____
☐ EKG(s)_____
☐ History and Physical(s) _____
☐ Inpatient Rounds Note(s)_____
☐ Laboratory Report(s) _____
☐ Mental Health / Psychosocial Report(s) _____
☐ Operative Report(s) _____
☐ Outpatient Clinic Note(s)_____
☐ Pathology Report(s) _____
☐ Pathology Slides/Block(s) _____
☐ Radiology CD/Film(s) _____
☐ Radiology Report(s)_____
☐ Records brought to COH _____
☐ Records from External Care Provider(s) _____
☐ Scan(s) _____
☐ Other_____
_____

MY HIGHLY CONFIDENTIAL INFORMATION: By checking the box(es) and placing my initials next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the type of highly confidential information indicated next to my initials, if any such information will be used or disclosed pursuant to this Authorization:

INITIALS

☐ _____ Information about Mental Illness or Developmental Disability Treatment
☐ _____ Information about HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
☐ _____ Information about Substance Abuse Treatment (i.e. alcohol or drug)
☐ _____ Information about the existence of Genetically Handicapping Conditions.

CITY OF HOPE

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

AFFIX PATIENT IDENTIFICATION LABEL HERE

MRN _____
Patient Name _____
Date of Birth _____

PURPOSE: I authorize COH to use/disclose my health or highly confidential information I selected above, if any, during the term of this authorization for the following specific purpose(s):
[Note: "At the request of the patient" is sufficient if patient is initiating this Authorization.]

_____

RECIPIENT: PLEASE RELEASE MY INFORMATION TO / OBTAIN INFORMATION FROM:

Name: _____ Attn/Dept: _____

Address: _____

City/State/Zip Code: _____

Phone Number: _____ Fax Number: _____

TERM: ☐ This Authorization shall remain in effect from the Date of this Authorization until the _____ day of _____, 20_____, or until COH fulfills this request, whichever occurs first.

☐ Other:

I understand that release or transfer of the disclosed information by COH to any person or entity not specified in this Authorization is prohibited by law. However, once COH discloses my health information to the recipient designated by me above, COH cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at COH, except, if my treatment at COH is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case COH may refuse to treat me if I do not sign this Authorization.

I have a right to receive a copy of this Authorization. I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to the appropriate COH medical records department at the appropriate address listed below. The revocation will be effective immediately upon COH's receipt of my written notice of revocation, except that the revocation will not have any effect on any action taken by COH in reliance on this Authorization before it received my written notice of revocation. I may contact the COH medical records department at the locations I have been treated during regular hours, Monday – Friday, 8:00 a.m. – 4:30 p.m.

☐ **City of Hope National Medical Center**
1500 East Duarte Road
Duarte, CA 91010
Phone: 626-256-4673 ext. 62446
Fax: 626-301-8443

☐ **South Pasadena**
209 Fair Oaks Avenue
South Pasadena, CA 91030
Phone: 626-396-2900
Fax: 626-396-2911

☐ **Antelope Valley**
44105 15th Street West
Suite 409
Lancaster, CA 93534
Phone: 661-902-5600
Fax: 661-951-0686

☐ **Santa Clarita**
23861 McBean Parkway
Suite B14
Santa Clarita, CA 91355
Phone: 661-799-1999
Fax: 661-799-0829

All written reports will remain at COH as part of your permanent file, including records from external care providers. All requests for copies of records for personal use may be charged at a rate of $15.00 for the first 60 pages, and 25¢ per page thereafter. Please allow 15 business days for completion of personal copy processing.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below I hereby, knowingly and voluntarily, authorize COH to use or disclose my health information in the manner described above.

_____ _____ _____ _____

Printed Name of Patient (or Personal Representative) *Signature of Patient (or Personal Representative)* *Date* *Time*

IF PERSONAL REPRESENTATIVE HAS SIGNED ABOVE, INDICATE YOUR RELATIONSHIP TO THE PATIENT:

☐ Parent ☐ Guardian ☐ Conservator ☐ Agent ☐ Other_____

Identity of Personal Representative verified via ☐ Photo ID ☐ Matching Signature ☐ Other _____