



City of Hope National Medical Center ("COHNMC")

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 [ ] Request a copy of the medical records for a second opinion.
(Please check all that apply): [ ] Request a copy of the medical records be sent to another provider or entity.
[ ] Request for medical records from another provider be sent to COHNMC.

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 \_\_\_\_\_ [ ] Outpatient Clinic Note(s) \_\_\_\_\_
[ ] Chemotherapy Flowsheet(s) \_\_\_\_\_ [ ] Pathology Report(s) \_\_\_\_\_
[ ] Consultation Report(s) \_\_\_\_\_ [ ] Pathology Slides/Block(s) \_\_\_\_\_
[ ] Discharge Summary(ies) \_\_\_\_\_ [ ] Radiology CD/Film(s) \_\_\_\_\_
[ ] EKG(s) \_\_\_\_\_ [ ] Radiology Report(s) \_\_\_\_\_
[ ] History and Physical(s) \_\_\_\_\_ [ ] Records brought to COHNMC \_\_\_\_\_
[ ] Inpatient Rounds Note(s) \_\_\_\_\_ [ ] Records from External Care Provider(s) \_\_\_\_\_
[ ] Laboratory Report(s) \_\_\_\_\_ [ ] Scan(s) \_\_\_\_\_
[ ] Mental Health / Psychosocial Report(s) \_\_\_\_\_ [ ] Other \_\_\_\_\_
[ ] Operative Report(s) \_\_\_\_\_

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:

✓ Initial
[ ] \_\_\_\_\_ 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 National Medical Center
1500 East Duarte Road, Duarte, CA 91010
Authorization to Use and Disclose
Protected Health Information

Patient Identification / Label: Page 1 of 2
MRN \_\_\_\_\_
Patient Name \_\_\_\_\_
Date of Birth \_\_\_\_\_

**PURPOSE:** I authorize COHNMC 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 for a maximum of six (6) months from the date of signature, or until the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

I understand that release or transfer of the disclosed information by COHNMC to any person or entity not specified in this Authorization is prohibited by law. However, once COHNMC discloses my health information to the recipient designated by me above, COHNMC 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 COHNMC, except, if my treatment at COHNMC is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case COHNMC 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 COHNMC's Health Information Management Services (HIMS) at the address listed below. The revocation will be effective immediately upon COHNMC's receipt of my written notice of revocation, except that the revocation will not have any effect on any action taken by COHNMC in reliance on this Authorization before it received my written notice of revocation. I may contact COHNMC during regular hours, Monday-Friday, 8:00 a.m. – 4:30 p.m. as follows:

City of Hope National Medical Center – Health Information Management Services  
1500 E. Duarte Rd, Duarte, CA 91010-3000; Tel: (626) 256-4673 Ext. 62446; Fax: (626) 301-8443

All written reports will remain at COHNMC 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 COHNMC 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 the patient is a minor or is otherwise unable to sign this Authorization, please indicate the relationship of the Personal Representative to the Patient:  Parent  Guardian  Conservator  Agent Other \_\_\_\_\_

Identity of Personal Representative verified via  Photo ID  Matching Signature  Other, specify: \_\_\_\_\_