



City of Hope National Medical Center ("COHNMC")

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

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) - _____

I would like to (*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 COHNMC.
Date Needed By: _____

This authorization applies to the following information: (Specify information requested by checking box(es) 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.)

<input type="checkbox"/> History and Physical(s) _____	<input type="checkbox"/> Clinic Note(s) _____
<input type="checkbox"/> Discharge Summary(ies) _____	<input type="checkbox"/> Pathology Slides/Block(s) _____
<input type="checkbox"/> Operative Report(s) _____	<input type="checkbox"/> Radiology CD/Film(s) _____
<input type="checkbox"/> Pathology Report(s) _____	<input type="checkbox"/> Scan(s) _____
<input type="checkbox"/> Consultation Report(s) _____	<input type="checkbox"/> Chemotherapy Flowsheet(s) _____
<input type="checkbox"/> Radiology Report(s) _____	<input type="checkbox"/> Records brought to COHNMC _____
<input type="checkbox"/> EKG(s) _____	<input type="checkbox"/> Records from External Care Providers _____
<input type="checkbox"/> Laboratory Report(s) _____	<input type="checkbox"/> 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:

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

A separate authorization is required to authorize the disclosure of psychotherapy notes.

<p>City of Hope National Medical Center 1500 E. Duarte Road, Duarte, CA 91010</p> <p>Authorization to Use and Disclose Protected Health Information</p> <p>Form No. 8700-C035C (rev. 03/21/08) AUDPHI MEC: 04/07</p>	<p>Patient Identification/Label: _____ Side 1 of 2</p> <p>MRN _____</p> <p>Patient Name _____</p> <p>Date of Birth _____</p> <p>Original: Chart (HIPAA) Photocopy: Patient B:10/08</p>
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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 will remain in effect:

From the Date of this Authorization until the ____ day of _____, 200__ or until COHNMC fulfills this request, whichever occurs first.

Other _____

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. - 5:00 p.m. as follows:

City of Hope National Medical Center – Health Information Management Services – BC03
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 will be charged at a rate of \$10.00 + \$0.25 per page. Please allow 10 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. Signature of Patient:

_____ Date: _____ If patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

Signature of Patient's Personal Representative

Description of Authority

Date