CEDARS-SINAI

AUTHORIZATION FOR USE OR DISCLOSURE OF 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

Patient Information

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

Release To Request From

I authorize Cedars-Sinai to Release / Request Medical Records

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

Purpose

For the following:
___ Continuing Care
___ Insurance
___ Legal
___ Personal Use
___ Other: _____
_____

Information to Release

Treatment Dates: _____

___ Discharge Summary ___ Emergency Record
___ Operative Report ___ Billing Record
___ Laboratory Report ___ EKG
___ Pathology Report ___ Radiology Report
___ Consultation Report ___ Xray Film / Images CD
___ Other (*Please Specify*) _____
___ Outpatient / Clinic Record - Clinic / Provider Name:
_____

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

___ Mental Health ___ HIV test results
___ Alcohol / Drug Abuse

A separate authorization is required for psychotherapy notes.

Fees

Based on California Evidence Code Sections 1560-1567 Fees may be charged for medical record copies.

Health Information Management Department
8700 Beverly Blvd., Room 2901, Los Angeles, CA 90048
Email: GroupHIDInternetInquiries@cshs.org
Fax: 310-423-0113

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: _____ ❑ 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. 3. I may revoke this authorization at any time in writing, signed by me or on my behalf and delivered to **Cedars-Sinai Medical Center, Health Information Department, 8700 Beverly Blvd., Room 2901, Los Angeles, CA 90048.** 4. If I revoke this authorization, the revocation will not have any effect on any actions taken 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. 7. If this ❑ is checked, the Requestor will receive compensation for the use or disclosure of my information.
Expiration	Without my written revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 180 days from the date hereof, unless otherwise specified: _____
Signature	Signature: _____ *(Patient or Legal Representative)* Date: _____ Legal Representative Relationship: _____

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