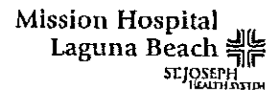

Patient's Name (Please Print) ________ **Social Security #** ________ **Date of Birth** ________

Address **Street** **City** **State** **Zip Code**

Phone Numbers – Home **Phone – Cell** **Phone – Work**

I hereby authorize Mission Hospital/CHOC Children's, 27700 Medical Center Road, Mission Viejo, CA 92691 or Mission Hospital Laguna Beach, 31872 Coast Highway, Laguna Beach 92651 to release information contained in my medical record only to the individual or organization listed below and only for the purpose specified below:

To: ________________________________

Name of Person or Organization (a fee is required when the patient, parent/legal guardian, conservator or executor is requesting copies or inspection for their own personal use)

Address Street City State Zip Code

Phone Number Fax Number

Information Requested or to be Released:

Date(s) of Service: ________________________________

Copies of the Medical Record (Check where applicable)

- ☐ Discharge Summary
- ☐ History & Physical Exam
- ☐ Consultation Report
- ☐ Operative Report
- ☐ Pathology Report
- ☐ Laboratory Reports
- ☐ X-ray Reports
- ☐ EKG Report
- ☐ Emergency Room
- ☐ Other ________________

☐ **Inspection of Record**

Purpose of need for disclosure (☐ personal use, ☐ insurance, ☐ medical care. etc.)

Other: ________________________________

Continued on back

AUTHORIZATION FOR RELEASE OF MEDICAL / PSYCHIATRIC / DRUG ALCOHOL INFORMATION

PATIENT I.D. LABEL

______ **Initial** I hereby consent to the release of any and all records containing alcohol and or drug abuse and or psychiatric diagnosis under the same consideration as outlined above. I understand that such information cannot be released without my specific consent, except in accordance with a court order (initials are required prior to release of medical records containing drug, alcohol or psychiatric information).

When the drug or alcohol abuse records are released, they must be treated as confidential under Federal Law (42 C.F.R. part 2). To release mental health records we must obtain authorization from the physician who attended the patient at Mission Hospital/CHOC Children's/Mission Hospital Laguna Beach and must be treated as confidential under State Regulation (Welfare & Institutions Code 5328).

I understand that the requester may not make further use of this disclosure for this information unless another authorization is obtained from me or unless Law specifically requires such use or disclosure. I further understand this consent may be revoked by me at any time by written notice of Mission Hospital/CHOC Children's/Mission Hospital Laguna Beach unless revocation has been received after the records have been released. This authorization will expire in six (6) months from the date signed unless otherwise specified.

I understand that I have a right to a copy of this authorization.

______________________________ ______________

Patient/Legal Guardian Signature **Date**

____

If signed by someone other than the patient, indicate relationship

THE FOLLOWING IS FOR HOSPITAL USE ONLY

PHYSICIAN RELEASE OF MEDICAL RECORD

☐ APPROVED

☐ DENIED – REASON FOR DENIAL: ______________________________

____

Physician Signature: ______________________________ Date ______________