STEP-BY-STEP INSTRUCTIONS TO COMPLETE THE REQUEST FOR RECORDS

Select the location(s) you need records from →

☐ Hoag Memorial Hospital Presbyterian Newport Beach ☐ Hoag Irvine ☐ Hoag Medical Group ☐ Hoag Urgent Care
☐ Hoag Physician Partners ☐ Hoag Concierge Medicine ☐ Hoag Specialty Clinic ☐ Hoag Orthopedic Institute

Name and Date of Birth of patient is needed →

Patient Name: _____ Date of Birth: _____

Use of disclosure: I hereby authorize Hoag Memorial Hospital Presbyterian, or the Hoag entity selected above and affiliates to disclose the information listed below to: (List the person/organization authorized to receive this information.)

Name and Address of where you want your records sent →

Name/Organization: _____
Address: _____
City: _____ State: _____ Zip: _____ Phone: _____

Checking one of these boxes tells us how you want to receive the records →

Media: ☐ Paper ☐ CD ☐ USB
How to receive: ☐ Mail ☐ Patient will pick up
☐ Authorized Representative will pick up:
Name: _____ Phone: _____
Electronic Option: ☐ Secured Email: _____
☐ MyChart (services on or after 4/28/18)
☐ Secure Medical Image Exchange (Radiology/Cardiology images only)
Email: _____

Dates of service →

Specific records requested (give approximate date if unknown) →

This authorization applies to the following:
☐ Only the following records or types of health information: Date of Service: _____
☐ ED Records ☐ History & Physical ☐ Consults ☐ Operative Report
☐ Discharge Summary ☐ MD Progress Notes ☐ MD Orders ☐ Nurse's Notes
☐ EKG, EMG, EEG ☐ Radiology Reports ☐ Anesthesia Records ☐ Lab/Pathology Reports
☐ Immunizations ☐ Radiology Images, Exam: _____ ☐ Other: _____

Special consent to release sensitive records. Check if applicable. →

I specifically authorize release of the following information (check as appropriate):
☐ Alcohol/drug treatment information ☐ HIV Test Results ☐ Mental Health Treatment Information
A separate authorization is required to authorize the disclosure or use of psychotherapy notes, as defined in the federal regulations implementing the Health Insurance Portability Accountability Acct (HIPAA).

This is what you are using the records for, what purpose →

Purpose for use/disclosure:
☐ Patient Request ☐ Further Medical Care ☐ Insurance **OR** ☐ Other: _____

How long you want this authorization to last →

Expiration:
This authorization will expire in 1 year from date of signature unless another date is specified: _____

IMPORTANT You MUST sign your request – unsigned requests cannot be processed. →

Signature: _____ Date: _____ Time: _____AM/PM
[Patient/Legal Representative]
If signed by other than patient, indicate legal relationship to patient: _____
Print Name (Legal Representative): _____