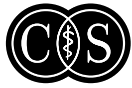

CEDARS-SINAI® | MEDICAL CARE FOUNDATION

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 ☐ Inspect/Review Medical Record

☐ Other ______________________________

PATIENT INFORMATION

Patient Name: ______________________________ MRN: ______________
Last Name: First Name:

Date of Birth: ______________________________ Phone: ______________

Address: ______________________________

City: ______________________ State: ________ ZIP: ____________

RELEASE TO / REQUEST FROM

I authorize CSMCF 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 ______________________________

Health Information Management Department
8501 Wilshire Blvd., Suite 200, Beverly Hills, CA 90211
Email: GroupMNSROI@cshs.org • Phone: 310-248-7057 • Fax: 310-248-7046

INFORMATION TO RELEASE

Treatment Dates: ______________________________

- ☐ Billing Record
- ☐ Radiology Report
- ☐ Urgent Care
- ☐ Operative Report
- ☐ Laboratory Report
- ☐ Pathology Report
- ☐ Consultation Report

☐ 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

There may be an administrative fee for obtaining copies of medical records and x-ray films. Costs for obtaining copies are available upon request.

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 records copies.

Relationship to Patient: ______________________________

☐ My CS-Link (Patient Portal)

☐ Email: ______________________________

☐ Other: ______________________________

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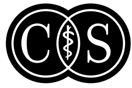 **CEDARS-SINAI** | MEDICAL CARE FOUNDATION

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 Care Foundation
   Health Information Department
   8501 Wilshire Blvd., Suite 200
   Beverly Hills, CA 90211

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.

EXPIRATION

Without my written revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 12 months from the date hereof, unless otherwise specified:

____

SIGNATURE

Signature: ______________________________ Date: ________________

(Patient, Power of Attorney for Healthcare or Legal Representative)

Legal Representative Relationship: ______________________________

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