Western University of Health Sciences
Patient Care Center

795 E. Second Street
Pomona, CA 91766-2007
Tel: (909) 706-3900
Fax: (909) 706-3785

8686 Haven Avenue, Suite 200
Rancho Cucamonga, CA 91730-9110
Tel: (909) 706-3950
Fax: (909) 706-3785

Authorization for Release of Medical Records from Outside of WesternU

It is my understanding that I have the legal right, with certain limitations, to either view or obtain copies of my protected health information, or that of my unemancipated minor child whose treatment I authorized. This right is also granted to the guardian of a minor child and to the conservator of a person. Further, I understand that when deemed advisable by a healthcare provider, this right may be denied pursuant to the law. In such an event, I will be advised of my options.

I hereby request that _____
provide access to or release of the medical record for the following patient:

Printed Patient Name_____ Medical Record #_____

Date of Birth_____ Social Security #_____

Address_____ City_____ State_____ Zip Code_____

Phone #_____ Fax #_____ Email_____

The above named facility/healthcare provider may release the records to (Circle the office records are to be sent to):

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Pomona, CA 91766-2007
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Rancho Cucamonga, CA 91730-9110
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Dates of records to be released: ❑All dates ❑From _____ to _____

Description of the records to be released:

❑All records ❑Lab results ❑Pharmacy ❑Immunization ❑Billing records
❑Diagnostic images ❑Other. Specify (be as specific as possible): _____
_____
_____

I understand that my medical records may contain information related to HIV/AIDS test results; drug & alcohol abuse, diagnosis or treatment; and/or mental health. **Please check the appropriate box below if you are specifically authorizing the release of these records (Otherwise, this information will be excluded):**

❑HIV/AIDS test results (Cal. Health & Safety Code § 120980(g)) ❑Mental health
❑Drug & alcohol abuse, diagnosis or treatment (42 CFR §§ 2.34-2.35)

This disclosure can be used for the following purpose(s): ❑Personal Use ❑Legal ❑Insurance ❑Medical Treatment
❑Medical Condition Verification ❑Disability ❑FMLA ❑Workers' Comp ❑Other. Specify: _____

The type of access requested is: ❑ Inspection of the records in person ❑ Copies of the record

Media Type (for copies): ❑ Electronic ❑ Paper

Form of Delivery (for copies): ❑Pick up ❑Mail ❑Fax ❑Email (note documents will be sent in encrypted format)

Duration: Unless revoked earlier, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

Revocation: I understand that I may cancel this authorization by submitting a written request to the above named facility/healthcare provider. My cancellation will not affect information that was released prior to receipt of the written request.

Redisclosure: I understand that once this information is released, the recipient could potentially redisclose it to a third party, and it may not be protected by federal privacy law (HIPAA).

I understand that signing this form is voluntary, and that I need not sign this authorization form as a condition to receiving healthcare treatment from the above named facility/healthcare provider.

Printed Name of Person making request: _____

Relationship to Patient, if not Patient: _____
(Guardian, Conservator, or other Legal Representative must attach written legal proof of such status.)

Signature_____ Date_____

Note: A photocopy or electronic scan of this document shall be as valid as an original

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FOR OFFICE USE ONLY

Processing Date: _____Total amount of fees: $_____ Paid by CK# _____ Credit/Debit Card Cash

Date mailed / Hand delivered: _____ Special handling requested: Yes No

Signature of Staff Completing Request: _____

Rev. 11-2016