

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

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 understand that there is a charge for obtaining copies of my medical record. The charge is \$15.00 for the first 40 pages, plus 25 cents per printed/copied page, or 50 cents per page if printed from microfilm.

I hereby request that Western University of Health Sciences (“WesternU”) provide access to or release of all of medical records unless otherwise indicated, for the following patient:

Printed Patient Name _____ **Medical Record #** _____
Date of Birth _____ **Social Security #** _____
Address _____ **City** _____ **State** _____ **Zip Code** _____
Phone # _____ **Fax #** _____ **Email** _____

WesternU may release the records to: **Check if same as above**

Recipient Name _____
Address _____ **City** _____ **State** _____ **Zip Code** _____
Phone # _____ **Fax #** _____ **Email** _____

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
 Records **ONLY** from: ___Pharmacy ___Eye Care Institute ___ Medical Center ___ WDI ___ Foot & Ankle Center
 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 WesternU. 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 WesternU.

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 of Witness _____ Date _____

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

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: _____