Medical Record Authorization Form Instructions

►Important: Please download and save a copy of this form before filling it out.◄

How to Complete the Medical Record Authorization Form

- **Are you the patient?**
  - Answer "**Yes**" if you are the patient or "**No**" if you are the patient's legal or personal representative.
    - **NOTE**: If you answer "No, I am the patient's legal/personal representative", you may be asked to provide supporting documentation that gives you the authority to request medical records on the behalf of the patient.
- **Patient Information**
  - Enter the patient's First and Last Name, Middle Initial (if any), date of birth, full address, phone number, and the patient's email address (required for contact purposes)
- **Who do you want to request records from?**
  - Enter the name of the CLCHC facility or CLCHC doctor's full name, address, phone number and fax number.
- **Where do you want the records sent to?**
  - Check the box if you want records sent to the patient only.
    You can then skip to the next section if the recipient's information is the same as the Patient Information.
  - If records will be sent to someone other than the patient, enter the recipient's full name, address, city, state, zip code, recipient phone number, recipient fax or email.
- **What is the reason for requesting records?**
  - Choose the appropriate reason for requesting records. **Check only one (1)**.
- **What treatment dates of service are you looking for?**
  - List the approximate date range for the treatment dates of service you need to the best of your ability.
- **What types of records would you like? (Check all that apply).**
  - **Clinic/Doctor's Office Visit Notes – ALL Providers**:
    Select only if you want notes from any physician the patient may have seen.
  - **Following Specific Providers(s) ONLY**: Select only if you want notes from a specific doctor's visit.
    Please give us the name of the treating provider to expedite your request.
  - **Hospital Records**:
    Select only if you want records from inpatient hospitalizations or emergency room visits at one of our partner hospitals.
  - **Immunizations**: Select only if you want immunization/vaccination records (e.g. flu shots, DTAP, etc.).
  - **Lab Test Results**: Select only if you want lab test results (e.g. urinalysis, CBC, etc.).
  - **Radiology Reports (CT, MRI, X-ray, etc.)**: Select only if you want a copy of radiology exam results (printed form).
    NOTE: To request radiology images, there is an additional fee listed below.
  - **Operative Reports/Procedure Notes**:
    Select only if you want a copy of the operative report or procedure note of the patient's surgeries or procedures.
  - **Physical/Occupational/Speech Therapy Records**:
    Select only if you want copy of physical therapy, occupational therapy, or speech therapy records.
  - **Other**: Select only if you are seeking records not listed above. You can provide specific details in the next section.

Medical Record Authorization Form Instructions

- **Please describe the specific records you're requesting to help us respond more completely to your request. (Example: Related to a condition or surgery, specific lab tests, all available records, etc.).**
  - This section is optional. Enter additional details as desired related to the types of records you need.
- **Do we have permission to release the following protected information that may be contained in your medical records?**
  - Please check all that apply. Leave blank if none of them apply to the requested records.
- **Is there a deadline for this request?**
  - Answer **"Yes, I have a deadline."** if you have a deadline and specify the date you need the records
  - Answer "**No, just as soon as possible.**" if you don't have a specific deadline.
    - **NOTE**: California law allows healthcare providers up to 15 days to fulfill your request.
- **How would you like us to send the records? **Must select one (1) option ONLY***
  - Tell us how you would like to receive the records. **Check only one (1) option from the list.**
- **Expiration Date (Optional)**. The authorization will be effective for one (1) year from the date you sign it unless you specify otherwise. You have the right to give us an alternative expiration date. However, if you do, it must be dated at least 15 days in the future from Today's date to allow ample time to process your request as permitted by California law.
- **Your Rights Under the Law**. This section is informational only. It explains your rights under state and federal privacy laws.
- **Signature and Date**. A signature and date are required for the authorization to be valid.
  If you are completing the authorization on behalf of the patient, also print your name and your relationship to the patient.

Additional Requirements:

- Photo ID: Must include a legible copy of your photo ID or other government-issued ID along with the authorization form for identity verification purposes. If picking up the records in-person, you will be asked to provide your photo ID at that time.
- You can also visit a Notary Public who can complete and attached CA Notary Public form to this Medical Record Authorization Form verifying your identity.
- Pursuant to Health & Safety Code section 123110, we can charge 25 cents per page plus a reasonable clerical fee. For diagnostic films, such as an x-ray, MRI, CT and PET scans, you can be charged the actual cost of copying the films. This only applies if you have made a written request for a copy of your medical records to be provided to you.
- If you are someone other than the patient: In addition to a Photo ID, please include a copy of valid supporting documentation that gives you authority to request records on behalf of the patient. (Exception: Parents of minor patients).
  Acceptable forms of supporting documentation include:
  - *Advanced Healthcare Directive* (must be in effect at time of requesting records)
  - *Death Certificate*
  - *Executor of the Estate* (for deceased patients only)
  - *Power of Attorney* (must include a provision that allows medical decision-making and/or release of medical records)
  - *Power of Attorney for Health Care* (must include a provision that allows release of medical records)
  - or some other form of documentation (subject to final review)

Thank you for selecting Celebrating Life Community Health Center as your provider of choice.

CELEBRATING LIFE
COMMUNITY HEALTH CENTER

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT LABEL

Are you the Patient?

☐ Yes ☐ No, I'm the patient's legal/personal representative*

**Note: If you're not the patient, you may be asked to provide supporting documentation to verify that you are authorized to make this request on behalf of the patient.*

Patient Information

Patient Name:		Date of Birth:	
Address, City, State, ZIP:			
Patient Phone:		Email:	

Who do you want to request records from?

Healthcare Provider or Facility Name:	
Address, City, State, ZIP:	
Phone:	Fax:

Where do you want the records sent to? *Note: We can release information only to who you authorize.*

☐ **Check this box if records are being sent to the patient only. No further action in this section needed.**

Recipient Name:			
Recipient Address, City, State, ZIP:			
Recipient Phone:		Recipient Fax or Email:	

What is the reason for requesting records?

☐ I'm moving and/or switching doctors ☐ Getting a second opinion ☐ Seeing a Specialist
☐ Military Enlistment ☐ Personal Use ☐ Other reason: _____

What treatment dates of service are you looking for?

Specify an approximate* date range – Start: ____/____/____ to End: ____/____/____
**Date range doesn't have to be exact. Enter dates to the best of your ability.*

What types of records would you like? *Note: Some records may only be available on paper or PDF.*

☐ Clinic/Doctor's Office Visit Notes – ALL Providers ***OR*** ☐ Following Specific Provider(s) ONLY:

_____

☐ Hospital Records ☐ Immunizations ☐ Lab Test Results ☐ Radiology Reports (CT, MRI, X-ray, etc.)
☐ Operative Reports/Procedure Notes ☐ Physical/Occupational/Speech Therapy Records
☐ Home Health Records ☐ Other (Please specify)

Please describe the specific records you're requesting to help us respond more completely to your request. (Example: related to a condition or surgery, specific lab tests, all available records, etc.)

Do we have permission to release the following protected information* that may be contained in your records? Please check all that apply below. **Additional authorization may be required.*

☐ HIV Test Results ☐ Substance Use/Drug Abuse Records
☐ Mental Health Records ☐ Genetic Testing Results

CELEBRATINGLIFE
COMMUNITY HEALTH CENTER

PATIENT LABEL

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Is there a deadline for this request?

By law we have up to 15 days to fulfill your request. However, if you have an urgent need for an upcoming appointment, please let us know. We will do our best to honor your deadline.

☐ Yes, I have a deadline. Date needed: _____ ☐ No, just as soon as possible.

How would you like us to release the records? *Must select one (1) option ONLY*

☐ Patient Portal (My Health Online) ☐ Email (encrypted) ☐ Email (unencrypted)*

☐ Fax (50-page limit) ☐ CD (encrypted) by Mail ☐ CD (encrypted) by In-Person Pickup

Per Page Fees May Apply: ☐ Paper by Mail ☐ Paper by In-Person Pickup

For Additional Fee: ☐ USB flash drive (encrypted) by Mail ☐ USB flash drive (encrypted) by In-Person Pickup

**Sending information by unencrypted email increases the risk of being read by an unauthorized third party.*

Expiration Date

This authorization shall become effective immediately and remain in effect for one (1) year from the date signed below unless specified here*: _____

**Optional Expiration Date (must be at least 15 days in the future from Today's date to be valid)*

Your Rights Under the Law

- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment or payment.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and mailed to this address:
  - CLCHC, Attn: Medical Records, 27800 Medical Center Road, Suite 108, Mission Viejo, CA 92691
- My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.
- I have the right to receive a copy of this authorization.
- I may inspect and obtain copy of my health information for which I am authorizing the use or disclosure for as long as the information is maintained by the affiliate(s) listed above.
- The location(s) listed above will not receive compensation for the use or disclosure of my health information.
- I understand that California law prohibits the recipients of my health information from making further disclosure of my health information unless the recipient obtains another authorization from me or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

SIGNATURE AND DATE *(As required by law)*

SIGNATURE: _____ Date: _____ Time: _____

(Patient or Legal/Personal Representative*)

*If signed by someone other than the patient, print name and specify relationship to the patient:

Name: _____ Relationship: _____

NOTARY PUBLIC COMMENTS