



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):

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

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

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: _____