TORRANCE MEMORIAL | An Affiliate of Cedars Sinai

Authorization for the Use or Disclosure of Protected Health Information

Completion of this document authorizes the use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Provide all information requested to ensure this authorization is valid. I hereby authorize Torrance Memorial Medical Center to use or disclose my protected health information as follows:

PATIENT IDENTIFICATION	
Patient Name:	
Date of Birth:	Phone Number:

Method of Delivery: ☐ Pick-up ☐ Mail ☐ Patient Portal Access ☐ Powerchart Access

Format: ☐ Paper Copy ☐ Electronic (CD)

(for employees, please see note on pg. 2).

RELEASE TO			
Patient/Person/ Organization Name:			
Address	City	State	Zip Code
Email address	Phone No.	Fax No (Clinic Only):	

I REQUEST COPIES OF MY MEDICAL RECORDS	
☐ For my physicians	☐ For my personal use

TYPE OF INFORMATION TO BE RELEASED

This authorization applies to the following information:

☐ Doctor's Report ☐ Emergency Room Report ☐ Test Results ☐ Other _____

☐ Statement of Detailed Charges (For billing records, please see the Business Office).

Radiological Images: ☐PET Scan ☐ MRI ☐ CT scan

☐ Sexually Transmitted Diseases ☐ Reproductive Health ☐ Gender Affirming Care

I understand that my reproductive health records are protected under state law and cannot be disclosed without written consent unless otherwise provided for by the regulations. (CA Civ. §56.110, CA Health & Safety Code § 130290, CA AB 352).

Approximate date of service(s): _____ To: _____

_____	I understand the information to be released may refer to any drug, alcohol, psychiatric and/or mental health conditions.

EXPIRATION AND SIGNATURE:

This authorization is valid for the above-requested service date. It expires one year from the date signed or otherwise specified by the patient or representative.

Signature: _____ **if patient is unable to sign, sign and state your legal relationship to the patient and present appropriate identification and/or documentation.	Date: Time:	Check one: ☐ Patient ☐ Spouse ☐ Representative ☐ Other: _____

NOTICE OF RIGHTS AND OTHER INFORMATION:

Under the Health Insurance Portability Accountability Act (HIPAA) regulation 45CFR §164.524:

- You may refuse to sign this Authorization. We cannot release your medical records to you or the requestor if you do.
- You may revoke this authorization at any time. The revocation must be in writing, signed by you or on your behalf, and delivered or mailed to the:

  Health Information Management Department
  Torrance Memorial Medical Center
  3330 Lomita Blvd.
  Torrance, CA. 90505
- Your revocation will be effective upon receipt but will not be effective to the extent that the requestor or others have acted in reliance upon this Authorization.
- You have a right to receive a copy of this authorization.
- Neither treatment, payment, enrollment, nor eligibility for benefits will be conditioned on you providing or refusing to provide this authorization.
- Information disclosed under this Authorization could be re-disclosed by the recipient. It may no longer be protected by federal confidentiality law (HIPAA). However, **California** law prohibits the person receiving your health information from further disclosing it unless another authorization for such disclosure is obtained from you or unless such disclosure is required or permitted by law.
- You may inspect or obtain a copy of the protected health information you asked to release.

REVOCATION OF REQUEST

☐ I would like to revoke this Authorization for Use or Disclosure of Protected Health Information request.

Signature:	Date:	Time:
If signed by someone other than the patient, state your legal relationship to the patient (representative, spouse, or next of kin):		
TMMC Representative Signature:	Date:	Time:

FOR OFFICE USE:

Records Received by:

HIM Representative Signature:	Date:	Time:

NOTE FOR EMPLOYEES:

This authorization expires upon separation from Torrance Memorial.

For employees authorized by a relative or another individual to access their medical records, this permission will expire one year from the date it was signed.