CEDARS-SINAI® | MEDICAL CARE FOUNDATION

Please complete the attached Medical Record Request Packet. It can either be mailed, emailed or faxed to:

Cedars-Sinai Medical Care Foundation

Health Information Management Department

4100 W. 190th Street #244A

Torrance, Ca 90504

EMAIL: GroupMNSROI@cshs.org PHONE: (310) 385-3488 FAX: (310) 248-7046

A fee may apply to your request.

There is **NO** fee if records are sent to another physician.

Please see below, for further information regarding other types of requests.

Medical Billing Requests

Phone: (310) 967-1623

Mark Taper Foundation Imaging Center (Films or Imaging Requests)

Phone: (310) 423-8000 Press #2 for Imaging
Fax: (310) 423-0330

Cedars-Sinai Medical Center (Medical Record Requests)

Phone: (310) 423-2259
Fax: (310) 423-0113
http://www.cedars-sinai.edu

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AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Failure to provide all information may invalidate this authorization

I would like to: ☐ *request a* ***PAPER*** *copy -OR-* ☐ *request an* ***ELECTRONIC*** *copy*

PATIENT INFORMATION

Name of Patient (*Please print clearly*) ____________ AKA ____________ Date of Birth ____________

Address ____________ City, State & Zip Code ____________ Contact Number ____________

SEND medical information TO:
(*Check* ☐ *if same as above*)

Name of Person/Facility to Receive Information ____________

Street Address ____________

City, State and Zip Code ____________

Telephone ____________

OR

REQUEST medical information FROM:
(*To be used when requesting outside records to come to Cedars- Sinai*)

Name of Medical Office/Provider ____________

Street Address ____________

City, State and Zip Code ____________

Telephone ____________ Fax Number ____________

PURPOSE

For the following:

☐ Continuing Care ☐ Insurance ☐ Legal ☐ Personal Use

☐ Other: ____________

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INFORMATION TO BE RELEASED

- ☐ Urgent Care
- ☐ EKG
- ☐ Immunization
- ☐ Radiology Report
- ☐ Consultation/Progress Note
- ☐ Laboratory Report
- ☐ Pathology Report
- ☐ Growth Chart
- ☐ Colonoscopy
- ☐ Mammogram
- ☐ Procedure Report

☐ Other (Please Specify): ______________________________

Please specify Treatment Dates for information selected above: ____________________

Health Care Provider: ______________________________

State/Federal Laws require specific authorization to release the following types of information below. Check the boxes if you want to include the mentioned information, otherwise, they will be excluded.

☐ Mental Health ☐ HIV test results ☐ Alcohol/Drug Abuse

A separate authorization is required for psychotherapy notes.

DELIVERY INSTRUCTIONS

Please select ***one*** of the following methods:

Paper

☐ Mail records directly to person or organization specified

☐ Call Requestor when records are ready for pick-up

I authorize______________________________to pick up my medical records.

(Name and Relationship to Patient)

Electronic

☐ My CS-Link (Patient Portal)

☐ Email: ______________________________

☐ Fax: ______________________________

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NOTICE OF RIGHTS

I understand that:

1. If I refuse to sign this authorization, my refusal will not affect my ability to obtain treatment.
2. I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
3. I may revoke this authorization at any time.
4. If I revoke this authorization, the revocation will not have any effect on any actions taken prior to receiving the revocation.
5. I have a right to receive a copy of this authorization.
6. Information disclosed pursuant to this authorization could be re-disclosed by the recipient, and may no longer be protected by federal confidentiality law (HIPAA). However, California law, prohibits the person receiving my health information from making further disclosure, unless another authorization for such disclosure is obtained from me, or such disclosure is specifically required or permitted by law.

EXPIRATION

Without my written revocation, this authorization will automatically expire upon satisfaction of the need for disclosure but in any event, will expire 12 months from the date hereof, unless otherwise specified: ____

SIGNATURE

Signature:____Date: ______________

(please print name and sign)

PERSONAL REPRESENTATIVE INFORMATION

A person who has the legal authority to act on behalf of the individual. A copy of a Power of Attorney or other legal document must be on file or submitted with this form.

__________________________________ __________________________

Printed Name and Signature of Representative Relationship to patient

________________ ___________________

Date Telephone

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