WesternU Health
Pomona

795 E. Second Street
Pomona, CA 91766-2007
Tel: (909) 706-3900
Fax: (909) 706-3785

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) ☐ Genetic Information (45CFR160 & 164)

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 _____ **Date**_____

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

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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: _____

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