Request for Release of Authorized Individual to Obtain a Copy of Protected Health Information

Medical Records Department; 3115 E. Guasti Rd. Ontario, CA 91761
Servicing All Locations: Ontario/Upland/Covina/Pomona/West Covina
MEDICAL RECORDS FAX#: (909) 786-4397

REQUEST SECTION

Patient Name: _____ **Medical Record:** _____

As required by the Health Information Portability and Accountability Act of 1996, you have a right to request the opportunity to inspect and/or copy health information that pertains to you. A "Health Care Provider" will evaluate your request and will either grant it or explain the reason why the request will not be granted. In the event that your inspection/copy request is not granted, you may request that the decision be reviewed by our facility's Privacy Officer.

I _____, give authorization to release the following diagnostic radiology records performed at Centrelake Imaging only:

☐ **From Dates of service ____/____/____ to ___/____/____** ☐ **Date of service ONLY: ____/____/____**

☐ **All available records to date**

Expiration date of this consent: ____/____/____ (If none indicated, this consent extends indefinitely)

The above listed records should be released to the following individual:

Authorized Individual's Legal Name: _____ Date of Birth: _____

I understand that this authorization is voluntary and it gives the authorized individual permission to accept my records for medical reasons only. Records will be released to this authorized individual only after proper identification (government issued ID w/ photograph) has been verified.

Signature of Patient/Guardian: **Date:** **Telephone Number:**

X_____ _____ _____

Created: 4/1/2015