Mountains Community Hospital
29101 Hospital Rd.
PO Box 70
Lake Arrowhead, CA 92352
909-436-3060
Fax: 909-337-5326

PATIENT'S REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

Requests are processed in the order received and may take up to ten working days to process.

Date: _____ M.R.# / Visit #: _____

Patient Name: _____ AKA / Other Names: _____

Date of Birth: _____ Phone: _____

Address: _____ City/State/Zip: _____

Covering the period of healthcare from *(date)* _____ to *(date)* _____

- **I understand that this authorization will expire once the requested information has been delivered.**
- **This request can be revoked upon a written request for cancellation.**
- **California law prohibits redisclosure without authorization unless required by law.**
- **Completion of this form authorizes the MCH HIM Dept to release your records as specified below.**

Check the appropriate boxes for the items you are requesting from your Health Information Records.

☐ **PERTINENT INFORMATION**	☐ **ADMINISTRATIVE INFORMATION**	**OTHER REQUESTS:**
Suitable for Physician Appointments and Personal use Includes: Includes Physician Documentation, Surgical Information, Medication Information, Lab/Rad Results.	Used for Legal and Social Security Cases Includes: Forms Signature Pages	☐ Nursing Documentation ☐ Immunizations ☐ Billing Summary ☐ Lab/Rad only ☐ Visit Log ☐ Coding Summary ☐ Other:

METHOD OF RELEASE:

☐ Pick-Up (you will be notified when records are ready)

☐ Fax To: _____

☐ Mail to:

RECIPIENT OF INFORMATION:

☐ Patient

☐ Physician _____

☐ Other _____

I SPECIFICALLY AUTHORIZE RELEASE OF THE FOLLOWING INFORMATION (check box and initial):

☐ **Mental Health Records _____** ☐ **HIV test results _____** ☐ **Substance Abuse Records _____**

PATIENT SIGNATURE _____ DATE _____

REPRESENTATIVE SIGNATURE: _____ RELATIONSHIP:_____

----------Do not write below the line - For Office Use Only ----------

Processed By: _____ Date: _____

ID Checked: _____ Date of Birth Checked: _____

REV: Jan 2017