



**COAST PLAZA  
HOSPITAL**

**AUTHORIZATION TO RELEASE  
PROTECTED HEALTH  
INFORMATION**

<b>Patient Information</b>	Patient Name		AKA/Maiden Name/Other	
	Address		City/State/Zip Code	
	Date of Birth	Phone	Email Address	
	/ /			
<b>Information to be Released From:</b>	Facility Name	Address	Phone #	Fax #
	Coast Plaza Hospital	13100 Studebaker Road Norwalk, CA 90650	(562) 868-3751	(562) 929-3582
<b>Information to be Released to:</b>	Name of Hospital/Clinic/Physician/Person			
	Street Address		City/State/Zip Code	
	Phone		Fax (Urgent patient care)	
<b>For What Purpose:</b>	<input type="checkbox"/> Continuation of Care <input type="checkbox"/> Insurance <input type="checkbox"/> Other (please specify): _____		<input type="checkbox"/> Personal Use <input type="checkbox"/> Legal <input type="checkbox"/> Disability	
<b>Information to be Released:</b>	Dates of Service: From _____ To _____			
	<input type="checkbox"/> History & Physical <input type="checkbox"/> Consultation Report <input type="checkbox"/> Pathology Report <input type="checkbox"/> Emergency Department <input type="checkbox"/> EKG Report <input type="checkbox"/> Physician Order <input type="checkbox"/> Medication Report <input type="checkbox"/> Records for Continuity of Care <input type="checkbox"/> Other _____	<input type="checkbox"/> Discharge Summary <input type="checkbox"/> Operative Report <input type="checkbox"/> Radiology Report <input type="checkbox"/> Laboratory Report/Result <input type="checkbox"/> Physician Progress Note <input type="checkbox"/> Nurses Note <input type="checkbox"/> Mental Health Evaluation <input type="checkbox"/> Records for Personal Use <input type="checkbox"/> Other _____		

**State/Federal laws require specific authorization to release the following types of Protected Health Information:**

\_\_\_\_\_ Mental Health/Psychiatric Treatment                      \_\_\_\_\_ Genetic Testing

\_\_\_\_\_ Alcohol/Drug Abuse Treatment                              \_\_\_\_\_ HIV/AIDS Test Results

**Please initial the line next to the information you are authorizing for release**

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<b>Authorization</b>	<ul style="list-style-type: none"> <li>• I understand that the completion and signing of this authorization is voluntary.</li> <li>• I understand that a photocopy of this authorization will be considered as valid as the original.</li> <li>• I understand that treatment, payment, enrollment or eligibility will not be conditioned upon my signing this authorization.</li> <li>• I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken.</li> <li>• I understand this authorization may be revoked in writing at any time except to the extent that action had been taken in reliance on this authorization.</li> <li>• To revoke this authorization, I must do so in writing and it must be sent to the facility I have authorized my information to be released from.</li> <li>• Unless otherwise revoked, this authorization will expire 180 days after the date of signing this form.</li> <li>• I understand that I have a right to receive a copy of this authorization.</li> <li>• I understand that a separate, specific authorization is required to authorize the disclosure or use of psychotherapy notes, as defined in the federal regulations implementing the Health Insurance Portability and Accountability Act.</li> </ul>
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**I understand that there may be a fee associated with this request.**

<input type="checkbox"/> Paper Records delivered by <input type="checkbox"/> Pickup at the Facility <input type="checkbox"/> Records in Electronic Format <input type="checkbox"/> I do want my records encrypted <input type="checkbox"/> I do Not want my records encrypted	<input type="checkbox"/> Mail <input type="checkbox"/> Fax Date: _____ <input type="checkbox"/> CD
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Signature of Patient or Authorized Representative	Printed Name	Date	_____ AM or PM Time
Relationship (if signed by other than patient)	Printed Name	Date	_____ AM or PM Time



PATIENT LABEL  
 Hospital & Clinic Staff:  
 Affix a patient label here if  
 providing records to the patient.