

**To Request a Copy of Your Imaging and/or Radiology Exam Images and Reports:**

- 1) Complete the attached form **“Authorization to Use and Disclose Protected Health Information.”**
  - a. **Demographic Information.** Please enter the following: name, address, phone, date of birth, last four digits of your Social Security Number.
  - b. **Section 1** asks, “What part of the medical record do I need?” The complete medical record contains every entry in our electronic system and may be considerably more information than you need. If you want more specific and/or limited information, choose the appropriate items under **[OR the records marked below:]**, i.e. Radiology Films, Radiology Reports, Photographs, videotapes, or digital or other images, etc.
  - c. **Section 2** does not need to be completed unless you are asking for records that are outlined in this Section. If you are asking for these records, then choose the appropriate item and include your signature where indicated. **If you are not** requesting records outlined in this Section, you do not need to complete this area of the form.
  - d. **Section 3** asks, “How would you like your request to be handled?” Please be advised that in order to process your request, a valid Photo ID with signature, must be included with your authorization form.
    - i. If you want someone to pick up your records on your behalf, please include the name of your *Representative* in the space provided. **Please instruct your Representative that they must present a valid Photo I.D. matching the name listed in this section to obtain your records.**
    - ii. If you want the information to be faxed, please provide the fax number.
    - iii. If any of the information is being faxed or sent to someone other than yourself; provide the name and address of the person who will receive your information.
  - e. **Section 4** asks, “How long is this authorization is valid?” If you do not list a specific date in the space provided, the authorization will be valid for a period of 90 days from the date of your signature. **This Section requires that you provide your initials in the space provided.**
  - f. **Section 5** outlines your *Individual Rights* as they pertain to this authorization form.
  - g. **Signature / Date / Time:** In order to process your request, this section must be completed.
- 2) **Cost For Processing:** A fee of \$0.25 per page will be assessed for paper copies. If you would like your information placed on a CD, a \$5.00 fee applies. If you have questions related to the cost of obtaining your records, please contact the facility directly.
- 3) Submit the completed authorization form in person, by fax or mail to the appropriate **Imaging & Radiology** location where your images or X-rays were taken.

**Long Beach Memorial Medical Center**  
403 Columbia Street  
Long Beach, CA 90806      Phone: (562) 426-2928

**Miller Children's Hospital Long Beach**  
2801 Atlantic Avenue  
Long Beach, CA 90806      Phone: (562) 426-2928

**Community Hospital Long Beach**  
1720 Termino Avenue  
Long Beach, CA 90804      Phone: (562) 494-0631

**Orange Coast Memorial Medical Center**  
18111 Brookhurst Street  
Suite 1400  
Fountain Valley, CA 92708      Phone: (714) 378-7572

**Saddleback Memorial Medical Center - Laguna Hills**  
24451 Health Center Drive  
Laguna Hills, CA 92653      Phone: (949) 452-3573

**Saddleback Memorial Medical Center - San Clemente**  
654 Camino de Los Mares  
San Clemente, CA 92673      Phone: (949) 489-4507

- Long Beach Memorial Medical Center
- Miller Children's Hospital Long Beach
- Community Hospital Long Beach
- Orange Coast Memorial Medical Center
- Saddleback Memorial Medical Center

## AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

1. I hereby authorize MemorialCare and/or its entity(ies) to use or disclose my health information as follows:

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address (Street, City/State, Zip):** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **SSN (last 4 digits):** \_\_\_\_\_

**Date(s) of Service:** \_\_\_\_\_

- Complete Medical Record     Pertinent Medical Record (Dictated Reports/Test Results)

[OR the individual records marked below:]

- History & Physical     Consultation Reports     Progress Notes     Discharge Summary
- Laboratory/Pathology Reports     EKG's     ECHO (Cardio) Tapes/Results
- Radiology Reports     Radiology Films
- Billing Records     Photographs, videotapes, or digital or other images
- Personal Health Profile (Please Include Name of Employer) \_\_\_\_\_
- Other \_\_\_\_\_

**2. \*Specific Authorization to Release Sensitive Records\***

I understand that this consent is to include disclosure of:

- HIV/AIDS     Psychiatric Records
- Alcohol and/or Drug Abuse Records     Sexually Transmitted Disease Information

**Patient/Patient Representative:** \_\_\_\_\_ **Relationship (if not patient):** \_\_\_\_\_

3. Purpose of the requested use or disclosure (information will be used for):

Patient/Representative Use **or**  Other (please specify) \_\_\_\_\_

4. Please issue records by:  CD **or**  Paper

5. I am requesting that the records identified above be handled in the following manner:

Mail To Address Listed Above     I will pick-up     Fax Number/Attn: \_\_\_\_\_

A Representative will pick-up on my behalf (list name of Representative) \_\_\_\_\_

Mail information to:  Clinic     Dr. Office     Hospital     Attorney     Other

Name/Address/Phone: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

