

To Request a Copy of Your Billing Records:

- 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 4 of SS#.
 - b. **Section 1** is asking you, “What part of the medical record do I need?” The complete medical record contains every entry into 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. Billing Records, 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** is asking you, “How would 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 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** wants to know, “How long 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/pg 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 **Patient Financial Services**.

By Mail:
MemorialCare Shared Services
c/o Patient Financial Services
P.O. Box 20894
Fountain Valley, CA 92728-0894

By Fax: 714-377-3572

In Person:

**Long Beach Memorial Medical Center
Miller Children's Hospital Long Beach**
2801 Atlantic Avenue
Long Beach, CA 90806

Phone: (562) 933-1141
Hours: 8:00 AM to 4:00 PM

Orange Coast Memorial Medical Center
9920 Talbert Avenue
Fountain Valley, CA 92708

Phone: (714) 378-7426
Hours: 8:00 AM to 4:00 PM

**Saddleback Memorial Medical Center
San Clemente**
654 Camino de Los Mares
San Clemente, CA 92673

Phone: (949) 489-4593
Hours: 8:00 AM to 4:30 PM

Community Hospital Long Beach
1720 Termino Avenue
Long Beach, CA 90804

Phone: (562) 498-1000
Hours: 8:00 AM to 4:00 PM

**Saddleback Memorial Medical Center
Laguna Hills**

24451 Health Center Drive
Laguna Hills, CA 92653

Phone: (949) 452-7050
Hours: 8:00 AM to 4:00 PM

- 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):** _____

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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: _____
