MEDICAL RECORD REQUEST

INSTRUCTIONS

1. **Authorization for Release of Information *Must* be completed by the person who the Records are being requested.**

   Minor records will only be released to a legal parent/guardian and proof will be required.

2. **List who is requesting the record.**
   List where the record will be sent.
   Include phone number where you can be reached.
   Include social security number.
   Include date of birth.

3. **NAME, ADDRESS AND PHONE NUMBER *MUST* be listed on the AUTHORIZATION FOR RELEASE OF INFORMATION. This will be to the agency or person/persons to where the information is to be sent.**

4. **All Medical Record requests take time to process.**
   There will be one to fourteen (1-14) days to process the Medical Record Request. *NO EXCEPTIONS*

5. **There will be a $20.00 fee *per episode* for reproduction of records each time the record is reproduced. Larger charts may require a higher reproduction fee depending on content and size (This includes clerical and processing costs.)**
   Cash, Cashier Check or Money Order. (NO PERSONAL CHECKS)

6. **Requests for records for disability claims generally are originated from the disability office. You complete an authorization form there to be sent to Tarzana Treatment Center. The Disability Office then assigns you an analyst who requests your records. These are then reproduced by Tarzana and sent directly to the Disability Office to the analyst and a bill is attached.**

   SSI advocates work much in the same way as the Disability Office.

7. **We are happy to accommodate your medical record needs, so please help us help you to the best of our ability with your patience, cooperation, and your understanding.**
   MAKE SURE TO FILL OUT EXPIRATION OF AUTHORIZATION (60 Days maximum)

If you should have further questions please ask to speak with the Health Information Management Department and we will be happy to assist you. Office hour's are- 8:30am – 4:30pm

Thank you,

Health Information Management Supervisor

TARZANA TREATMENT CENTERS, INC.
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
Health Information Management

I authorize **Tarzana Treatment Centers, Inc.** to release health information to:

Name of person or facility to receive health information

Specify name/title of person to receive health information, if known

Street Address, City, State, Zip Code

Contact Phone Number

FAX Number

PATIENT PLEASE *INITIAL* EACH ITEM FOR INFORMATION TO BE RELEASED:

____ Discharge Summary	____ Treatment Progress Letter	____ Billing Statements
____ History & Physical	____ Primary Care Clinic Records	____ Attendance
____ TB Test Results	____ Dates of Treatment	____ Laboratory Reports
____ Treatment Complete Letter	____ HIV/AIDS Test Results/ Treatment Information	____ Patient Progress in Treatment

____ Other: _____

SPECIFY THE DATE OR TIME PERIOD FOR INFORMATION SELECTED ABOVE:

☐ current treatment episode only ☐ past treatment episode

☐ dates from / / to / /

THE PURPOSE OF THIS RELEASE IS: (*check one or more*)

☐ At the request of the patient/patient representative

☐ Other: (*state reason*) _____

Patient's Name (Print)	*Social Security #*	*Date of Birth*	*MRN*

Initials of Patient or Personal Representative	*Date*

PLACE LABEL HERE

NOTICE

Tarzana Treatment Centers, Inc. (TTC) and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

MY RIGHTS

- I understand this authorization is voluntary. Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) to obtain information in connection with eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a claim, or 4) to create health information to provide to a third party.

- I may revoke this authorization at any time, provided that I do so in writing and submit it to the Health Information Department of Tarzana Treatment Centers, Inc., 18646 Oxnard Street, Tarzana, California 91356. The revocation will take effect when TTC receives it, except to the extent that TTC or other have already relied on it.

- Information disclosed pursuant to this Authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

- I am entitled to receive a copy of this authorization, and I may inspect or obtain a copy of the health information that I am being asked to disclose.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires_____
(Insert applicable date or event.)

If no date is indicated, this Authorization will expire thirty (30) days after the date of discharge.

SIGNATURE(S)

Patient or Patient's Legal Representative (Signature)	***Date***
	☐ AM ☐ PM
Name (Print)	***Time***

(If signed by someone other than the patient, state your relationship to the patient/authority.)

Witness (Only if patient is unable to sign) or Interpreter

Patient's Name (Print)	***Social Security #***	***Date of Birth***	***MRN***

PLACE LABEL HERE