Temecula Valley Hospital
Requesting Copies of Medical Record or Radiology Study

Per Federal and State laws and regulations, patient information is kept in strict confidence and only released with proper authorization. We offer the options described below to obtain copies of a patient's medical record or radiology study. If your physician is a member of the Temecula Valley Hospital, your physician has access to your medical record and radiology study through our electronic medical record system.

Online For the fastest response time, we encourage you to submit your medical record request through our online medical correspondence system from Arctrieval. To get started, just select "Medical Records" under the "Patient & Visitors" tab at www.TemeculaValleyHospital.com. You may also download a printable form.

Mail You may mail your written request to:

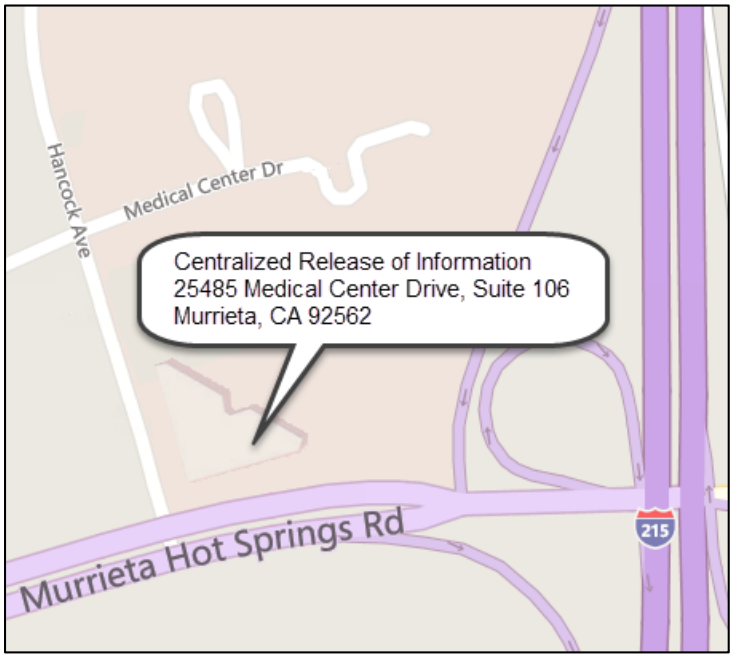
Health Information Management Department
Attn: Temecula Valley Hospital
25500 Medical Center Drive
Murrieta, CA 92562

Fax You may fax your written request to:

Health Information Management Department
Attn: Temecula Valley Hospital
(951) 600-4363

In-Person Assistance and Pickup

Medical records and radiology studies are NOT available to pick up at Temecula Valley Hospital.
All requests for a medical record or radiology study are managed by the Centralized Release of Information Department located at 25485 Medical Center Drive, Suite 106, Murrieta, CA 92562. The department is open from 8:30AM to 5:00PM Monday through Friday, excluding holidays.



Radiology Images and Studies

Radiology Images and Studies require one full business day to prepare. When scheduling a follow-up appointment please plan accordingly.

Copy Fees

As allowed by California Health and Safety Code Section 123110 there may be a fee required to reproduce copies of a patient's medical records.

Assistance

If you have any questions or would like additional information, please call us at (951) 696-6013, option #3.

Best Regards,

Release of Information Department
Management Consultants Unlimited, Inc.

Temecula Valley Hospital
Patient Record Request Order Form

Temecula Valley Hospital has established a relationship with Management Consultants Unlimited to manage the fulfillment of patient's medical record and radiology study requests. Our goal is to provide prompt service and deliver your health information in a timely manner.

Per CA Health and Safety Code Section 123110, Management Consultants Unlimited charges a fee for the cost of copying records as follows:

Number of Pages	Clerical Cost	Copy Charge	Shipping	Sales Tax
15 or fewer	$15.00	Included	Included	Included
16 or more	$6.00 per quarter hour	$.25 per page	Pickup or U.S. Mail	8.00%

Upon receiving your completed Release Authorization Form, this completed order form and your $15.00 deposit, we will begin processing your request. Do not send cash in the mail.

Your Name: _____ Today's Date: _____

Daytime Phone: _____ eMail Address: _____

Patient Name: _____ Patient DOB: _____

Deposit Method (To Be Completed by Patient or Patient's Representative

☐ **$15.00 Money Order (made payable to MCU)** ☐ **Credit Card (Visa, Master Card, Amex)**

Money Order #: _____ (made payable to MCU)

Credit Card Number: _____

Expiration Date: _____ Security Code: _____

Name on Credit Card: _____

Billing Address: _____

Billing City: _____ Billing State: _____ Zip: _____

Charged/Collected: ☐ **$15.00** ☐ **Other Amount: $** _____

I understand I am financially responsible for all the fees related to the production of medical records request from Temecula Valley Hospital. I hereby authorize Management Consultants Unlimited Inc. to charge my credit card for a $15.00 deposit and any additional amount for the reproduction of said medical records. Charges will appear on your statement as Management Consultants Unlimited.

Card Holder's Signature:		**Today's Date:**	

For Office Use	Receipt #	

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____

DISCLOSURE STATEMENT

I hereby authorize:

☐ Southwest Healthcare System (includes Rancho Springs & Inland Valley Medical Centers)

☐ Temecula Valley Hospital

☐ Other: _____

To release protected health information to the following person or entity:

Entity or Person: _____ Contact Name: _____

Address: _____ Telephone: _____

City, State, Zip: _____

HEALTH INFORMATION TO BE RELEASED

☐ Pertinent Information for Continuing Care

☐ History & Physical Exams
☐ Laboratory Reports
☐ Operative Reports
☐ Pathology Reports
☐ Billing Statements

☐ Radiology & Other Imaging Diagnostic Reports
☐ Images (X-rays, MRI, CT, etc ...)

☐ Consultation Reports
☐ Discharge Instructions
☐ EKG/ECHO
☐ ER Record

☐ Other: _____

I specifically authorize the release of the following information (check as appropriate):

☐ Alcohol or drug treatment information

☐ HIV test results

☐ Mental health treatment information (other than psychotherapy notes)

REQUESTED SERVICE DATES

Please indicate the date(s) and/or time period for the information selected above:

☐ Most Recent Visit ☐ Date(s): _____

PURPOSE OF RELEASE

Please indicate the purpose for this release (check one or more):

☐ Continuing Care ☐ Patient Copy ☐ Other: _____

INFORMATION DELIVERY

How would you like to receive the requested information?

☐ U.S. Mail

☐ Faxed to doctor's office or medical facility
Fax: _____

☐ Pick Up Centralized Release of Information Department
25485 Medical Center Dr., Suite 106 Murrieta, CA 92562,
Tel: (951) 696-6013

☐ Other: _____

MY RIGHTS

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits. I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of. I have a right to receive a copy of this authorization. Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may 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 for such disclosure is obtained from me unless such disclosure is specifically required or permitted by law.

I may revoke this authorization at any time, but I must do so in writing and submit it to the following address 25500 Medical Center Drive Murrieta, CA 92562. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

EXPIRATION

Unless, otherwise revoked, this Authorization expires _____ (insert date). If no date is indicated, it will expire upon its completion or 12 Months from date of signature, whichever comes first.

SIGNATURE

Signature: _____ Date: _____ Time: _____ AM/PM

Printed Name: _____ Telephone: _____

Relationship: _____ (If not patient)

Completed at time of record pickup:

Record picked up by:

Signature: _____ Date: _____ Time: _____ AM/PM

Printed Name: _____

Relationship: _____ (If not patient)

ID Type: _____ ID Number: _____

ID Verified by: _____

For Office Use Only

Records released from

☐ Medical Records ☐ Laboratory ☐ Radiology

☐ Emergency Department

☐ Nursing Unit, Unit Name: _____

☐ Other: _____

ID Type: _____ ID Number: _____

Witness Signature: _____ Date: _____ Time: _____ AM/PM

Witness Printed Name: _____