



PATIENT REQUEST FOR PROTECTED HEALTH INFORMATION

FROM WHOM (Specify clinic, specialty, or physician below.)

☐ Loma Linda University Medical Center (LLUMC)

☐ Loma Linda University Children's Hospital (LLUCH)

☐ Loma Linda University Health Care (LLUHC)

☐ Loma Linda University Medical Center - Murrieta (LLUMC-M)

☐ Other (Specify Provider/Facility): _____

RELEASE INFORMATION TO:

Name of Person / Facility to Release Health Information

Email

Phone

Street Address

City

State

Zip Code

INFORMATION TO BE RELEASED

Dates of Treatment/Date Range: _____

☐ Discharge Summary ☐ Standard Pertinent Documents ☐ Diagnostic/Test Reports

☐ Diagnostic Images ☐ Clinic Notes ☐ Other, Specify _____

☐ I specifically authorize release of: HIV test results, substance use, and Mental Health Records

Purpose of the request: ☐ Continued Care - Next Appointment Date: _____ ☐ Personal Use

RELEASE FORMAT

☐ **ELECTRONIC:** No cost (please check one of the delivery options below)

☐ Encrypted email

☐ MyChart**

☐ Fax Number (Not for Patients): _____

☐ **PASSWORD-PROTECTED CD OR** ☐ **CD WITH NO PASSWORD*:** \$6.50 fee per CD (please check one of the delivery options below):

☐ Mail

☐ Pick-up

* **ATTESTATION:** I understand that requesting my health information in an electronic format that is not encrypted or password-protected can place my health information at risk of being read or accessed by others. My initials below indicate that I want my health information in this format, and that I am acknowledging and accepting these risks.

* Please provide initials here: _____

Patient Name (Last, First MI) _____ Last four digits of SS#: _____

Birth Date ____/____/____ Phone Number: (____)____-____ Email: _____

Signature, Patient or Legal Representative

Date: ____/____/____

Legal Representative Name (Last, First, MI)

Relationship to Patient (if signed by Legal Representative)

Signature of Minor age 12 – 17 required for authorizing the release of their sensitive records (i.e., HIV, Mental health, Substance Abuse, Reproductive health, etc.)

Printed Name

** Who can request records in MyChart:

o If you are a proxy to a patient's MyChart account please refer to our website <https://lluh.org/patients-visitors/patients/medical-records> for info in obtaining these records.

NOTE: There may be charges associated with processing a request and producing requested records

Paper Format Fee Applies

Page count	Fee	Per Page Cost	Postage
1-5	-	-	+ postage
6-24	\$6.00	-	+ postage
>26	\$6.00	\$.01¢	+ postage



Loma Linda University
Loma Linda University Medical Center
Loma Linda University Children's Hospital
Loma Linda University Medical Center - Murrieta
Loma Linda University Health Care

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PATIENT IDENTIFICATION