Temecula Valley Hospital
Requesting Copies of Your Medical Records

A medical record for every patient at Temecula Valley Hospital is maintained by the Health Information Management Department. Per Federal and State laws and regulations, these records are 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 from Temecula Valley Hospital. All releases of records will come from our department at the Rancho Springs Medical Center site. Also, if your physician is a member of the Temecula Valley Hospital, your physician has access to your medical records and imaging files through our electronic medical record systems.

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 from the website.

Mail

You may mail your written request to:

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

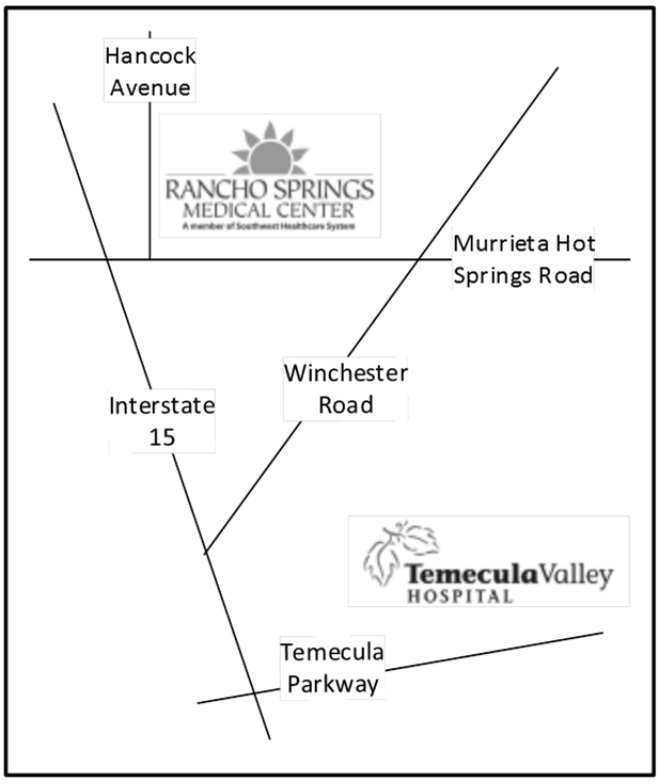
Fax

You may fax your written request to:

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

In-Person

Releasing medical records is done from a centralized office in the Administrative Services Building at Rancho Springs Medical Center. The office is located at 25520 Medical Center Drive in Murrieta and open from 8:30AM to 5:00PM Monday through Friday, excluding holidays.



Copy Fees

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

Assistance

If you have any questions or would like additional information, please feel to call us at (951) 696-6013 or visit us in-person and we will be happy to assist you.

Best Regards,

Release of Information Department
Management Consultants Unlimited, Inc.

Temecula Valley Hospital
Patient Pay Order Form

Temecula Valley Hospital has established a relationship with Management Consultants Unlimited to manage the patient pay program and fulfill all patient medical record 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 I 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 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, ☐ Rancho Springs Medical Center, ☐ Inland Valley Medical Center and/or ☐ Temecula Valley Hospital 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

☐ Billing Statements
☐ Consultation Reports
☐ Discharge Instructions
☐ EKG/ECHO
☐ ER Record
☐ History & Physical Exams
☐ Laboratory Reports
☐ Operative Reports
☐ Pathology Reports
☐ Progress Notes
☐ Radiology & Other Imaging Diagnostic Reports
☐ Images (X-rays, MRI, CT, etc ...)
☐ All Records

☐ 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): _____

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

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

☐ Hand Delivery

☐ Pick Up Rancho Springs Medical Center, Administrative Services Building, Medical Records Dept., 25520 Medical Center Drive, Murrieta, CA 92562, Tel: (951) 696-6013

☐ Faxed to doctor's office or medical facility

Fax: _____

☐ 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.

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

SIGNATURE

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

Printed Name: _____ Telephone: _____

Relationship: _____ (If not patient)

ID Type: _____ ID Number: _____

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

Witness Name: _____

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: _____