SOUTHWEST HEALTHCARE SYSTEM
INLAND VALLEY MEDICAL CENTER
RANCHO SPRINGS MEDICAL CENTER

How to Obtain Medical Records and/or Radiology Images

We offer the following options to obtain a patient's medical record or radiology images:

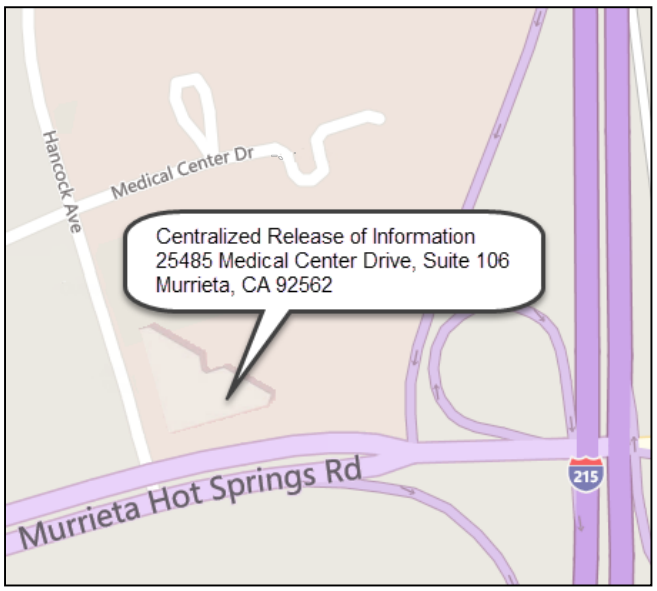
Online	Submit a request through our online medical correspondence system. To get started, just select "Medical Records" under the "Patient & Visitors" tab at: www.southwesthealthcaresystem.com	
Call or In Person	Visit the Centralized Release of Information (ROI) department. Our location and hours are below. You may also reach us by calling (951) 696-6013.	
Mail	Mail a written request to:	System Health Information Management Department Attn: Release of Information, Suite 106 25500 Medical Center Drive, Murrieta, CA 92562
Fax	Fax a written request to:	System Health Information Management Department (951) 600-4363

Patient Authorization

Patient information is kept in strict confidence and only released with proper authorization. The authorization is available online or in our office.

Processing Time

Please be assured we are committed to providing you a copy of your records or imaging study as quickly as possible and the same day if needed. Requests are processed in the order they are received. For urgent needs, please directly contact the ROI department.



Department Hours

The department is open from 8:30 AM to 4:30 PM Monday through Friday, excluding national holidays.

Department Location

The department is located at 25485 Medical Center Drive, Suite 106, Murrieta, CA 92562. It is on the corner of Murrieta Hot Springs Road and Hancock Avenue between Interstate 15 and Interstate 215. Please refer to the map.

Fees for Records

Depending on the purpose of your request, there may be a fee for a copy of the records. You will be advised of any potential fees when your request is submitted and again before it is completed.

Assistance

If you have any questions or would like additional information, please call us at (951) 696-6013, or visit us in-person. Our staff is ready and happy to assist you.

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: _____