

**Inland Valley Medical Center  
Rancho Springs Medical Center  
Requesting Copies of Your Medical Record**



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 Southwest Healthcare System, Inland Valley Medical Center or Rancho Springs Medical Center, 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 Arctrievial. To get started, just select “Medical Records” under the “Patient & Visitors” tab at [www.swhealthcaresystem.com](http://www.swhealthcaresystem.com). You may also download a printable form.

**Mail** You may mail your written request to: Health Information Management Department  
25500 Medical Center Drive  
Murrieta, CA 92562

**Fax** You may fax your written request to: Health Information Management Department  
(951) 600-4363

**In-Person Assistance and Pickup**

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**

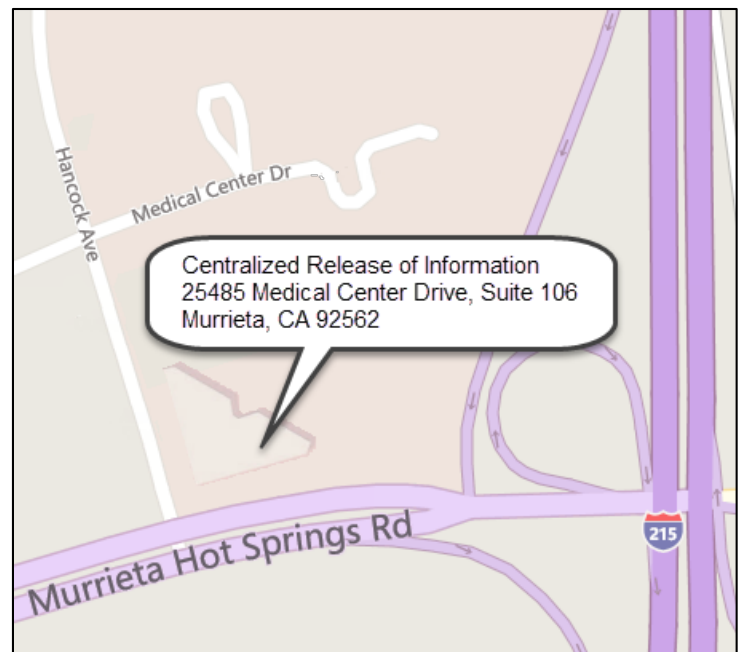
As allowed by California Health and Safety Code Section 123110 there is a fee to reproduce copies of a patient’s medical records.

**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,

Centralized Release of Information  
Management Consultants Unlimited, Inc.



**Inland Valley Medical Center  
Rancho Springs Medical Center  
Patient Record Request Order Form**



Southwest Healthcare System has established a relationship with Management Consultants Unlimited to manage the patient pay program and fulfill all patient 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 I request from Inland Valley Medical Center or Rancho Springs Medical Center. 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.**

<b>Card Holder's Signature:</b>		<b>Today's Date:</b>	
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<b>For Office Use</b>	Receipt #	
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# 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  Radiology & Other Imaging  Consultation Reports

Laboratory Reports  Diagnostic Reports  Discharge Instructions

Operative Reports  Images  EKG/ECHO

Pathology Reports (X-rays, MRI, CT, etc ... )  ER Record

Billing Statements

Other: \_\_\_\_\_

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

Alcohol or drug treatment  HIV test results  Mental health treatment information  
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

## PATIENT IDENTIFICATION



RI0020

INLAND VALLEY MEDICAL CENTER  
RANCHO SPRINGS MEDICAL CENTER  
TEMECULA VALLEY HOSPITAL



**AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION**

**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: \_\_\_\_\_

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**PATIENT IDENTIFICATION**



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