Notice to Patient / *Aviso al Paciente*

UCR Health processing and fees of requesting your Medical Records are as follows:
UCR Health procesamiento y las tarifas de solicitud de sus registros medicos son los siguentes:

- For Continued Care less than 24 hours / *Para Cuidado Continuo menos de 24 horas*:
  Free / *Gratis*

- For Personal Use less than 15 days / *Para Uso Personal menos de 15 dias*:

  - Paper Records / *Registros Medicos en Papel*

    First 10 pages **Free /** *Primeras 10 paginas* ***Gratis***

    $0.25 per page after 10 pages
    $0.25 por pagina despues de 10 paginas

  - Electronic Copy / *Copia Electronica*
    Email / CD $5.00 Correo Electronico/*Disco $5.00*

NOTE: All Mailed Records will have an additional $8.00 Admin/Postage Fee.

NOTA: Todos los registros enviados por correo tendran un cargo adicional de $8.00 por envio.

Medical Records - T: (844) 827-8000 F: (951) 344-5362

UCR HEALTH

Authorization for Release of Health Information

Patient Name: _____

Date of Birth: _____

Patient Address: _____
Street

_____
City State Zip Code

Phone Number: _____

Email Address: _____

Facility Use Only:

MRN: _____ Phone Call Date: _____

☐ Mailed: _____ ☐ Emailed: _____ ☐ Faxed: _____

How would you like to receive your records?

☐ Mailed - ☐ Paper ☐ CD
☐ Pick-Up - ☐ Paper ☐ CD
☐ Emailed
☐ Faxed(only to Continued Care)

I authorize UCR Health to release health information to: ☐ Self (Patient)

_____
Name of facility or person to receive health information

_____
Relationship and/or title of person to receive health information

_____
Street Address, City, State, Zip Code

_____
Phone Number Fax Number

Effective Period: *(Must select one)

☐ Last Office Visit **Or** ☐ _____(month/year) to _____(month/year)

Information to be Released:

☐ **Complete Medical Records**(Excluding Billing Records)
☐ **Complete Medical Records**(Including Billing Records)

☐ Clinic Visit Note
☐ Consultations
☐ Vaccinations/Immunizations
☐ Laboratory Reports
☐ Operative Reports
☐ Radiology Reports
☐ EKG ☐ CT Scan
☐ MRI ☐ X-Ray
☐ Other: _____

Specific Authorizations:

The following information will not be released unless you specifically authorize it by initialing and marking the relevant box(es) below:

_____ Initial ☐ I specifically authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment (42 C.F.R. §§2.34 and 2.35).

_____ Initial ☐ I specifically authorize the release of information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code §§5328, *et. seq.*).

_____ Initial ☐ I specifically authorize the release of HIV/AIDS testing information (Health and Safety Code 120980(g)).

_____ Initial ☐ I specifically authorize the release of genetic testing information (Health and Safety Code 124980(j)).

The purpose of this release is: (check one or more)

☐ Continuity of care or discharge planning
☐ Billing and payment of bill
☐ At the request of the patient/patient representative
☐ Other (state reason) _____

Expiration of Authorization:

Unless otherwise revoked, this authorization expires _____ (insert applicable date or event). If no date is indicated, this authorization will expire 12 months after the date of signing this form.

My Rights:

- I understand this authorization is voluntary. Treatment, payment enrollment or eligibility benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) obtaining information in connection with eligibility or enrollment in a health plan 3) determining an entity's obligation to pay a claim, or 4) creating health information to provide a third party. Under no circumstances, however, am I required to authorize the release of mental health records.
- I may revoke this authorization at any time, in writing and submit it to UCR Health Compliance 14350-2 Meridian Parkway, Riverside, CA 92518. The revocation will take effect when UCRH receives it, except to the extent that UCRH or others have already relied on it.
- I am entitled to receive a copy of this Authorization.

Personal Use:

_____ Initial — I understand I will be charged a per page fee for copies produced for my personal use.

Signature:

Date:_____

Time:_____ AM / PM

_____
Signature of Patient or Patient's Legal Representative

_____
Printed Name

_____
If signed by someone other than the patient, state your legal relationship to the patient/authority

Mail form with original signature to:
UCR Health Medical Records
900 University Avenue
MailCode 423
Riverside, CA 92521
Or
Fax to: (951) 344-5362

Notice:

UCRH and many other organizations and individuals such as physicians, hospitals, and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.