

## Authorization for Release of Health Information

<b>Patient Name:</b> _____ <b>Date of Birth:</b> _____ <b>Patient Address:</b> _____ <div style="text-align: center; margin-left: 150px;"><b>Street</b></div> _____ <b>City</b> _____ <b>State</b> _____ <b>Zip Code</b> _____ <b>Phone Number:</b> _____ <b>Email Address:</b> _____	<b>Facility Use Only:</b> MRN: _____ Phone Call Date: _____ <input type="checkbox"/> Mailed: <input type="checkbox"/> Emailed: <input type="checkbox"/> Faxed: _____
	<b>How would you like to receive your records?</b> <input type="checkbox"/> Mailed - <input type="checkbox"/> Paper <input type="checkbox"/> CD <input type="checkbox"/> Pick-Up - <input type="checkbox"/> Paper <input type="checkbox"/> CD <input type="checkbox"/> Emailed <input type="checkbox"/> MyChart <input type="checkbox"/> 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)

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<input type="checkbox"/> Clinic Visit Note	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Radiology Reports
<input type="checkbox"/> Consultations	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> EKG <input type="checkbox"/> CT Scan
<input type="checkbox"/> Vaccinations/Immunizations		<input type="checkbox"/> MRI <input type="checkbox"/> 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:

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

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

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

\_\_\_\_\_  I specifically authorize the release of genetic testing information (Health and  
 Initial      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:**

\_\_\_\_\_ I understand I will be charged a per page fee for copies produced for my **Initial** 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.