



UC San Diego

MEDICAL CENTER

| |
|------------------------------|
| Patient Name _____ |
| Date of Birth ____/____/____ |
| Phone # (____) _____ |
| MR# _____ |

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize _____ to release health information to:

Name of person or facility, which has information

Name of person or facility to receive health information

Specify name/title of person to receive health information, if known

Street Address, City, State, Zip Code

(_____) _____ Extension: _____

Telephone Number

TYPE OF RECORD

- Medical Billing Radiology images (X-rays, etc.)

INFORMATION TO BE RELEASED

- Inpatient dictated records (Discharge summary, History & Physical, Progress notes, operative reports, consultations, laboratory, radiology, and other diagnostic reports)
- Outpatient dictated records (Office notes, consultations, operative reports, laboratory, radiology, and other diagnostic reports)
- Immunization Records
- Emergency Department Reports

Sensitive Information

- HIV Test Results _____ Genetic Test Results _____
- Patient initials Patient initials
- Psychiatric treatment records _____
- Patient initials
- Drug & alcohol abuse treatment records _____
- Patient initials

SPECIFY THE APPROXIMATE DATES OF TREATMENT FOR INFORMATION SELECTED:



UC San Diego MEDICAL CENTER

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Identification

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

- Continuing medical care Inspection of record Insurance
 Legal matter Personal copy Other

Notice

UC San Diego Medical Center 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.

My rights

- I understand this authorization is voluntary. Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) to obtain information in connection with eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a claim, or 4) to create health information to provide to a third party.
- I may revoke this authorization at any time, provided that I do so in writing and submit it to:
 UC San Diego Medical Center
 Health Information Services
 200 W. Arbor Drive, # 8825
 San Diego, CA 92103-8825
- The revocation will take effect when UCSD Medical Center receives it, except to the extent that UCSD Medical Center or others have already relied on it.
- I am entitled to receive a copy of this Authorization.

Expiration of Authorization

Unless otherwise revoked, this Authorization expires¹ on: _____
(Insert applicable date or event)

Signature

(Signature of Patient or Patient's Legal Representative)

Date: _____

(Printed Name)

Time: _____ AM / PM

Relationship to patient (if other than patient): _____

(Footnotes)

¹ If no date is indicated, this Authorization will expire 12 months after the date of signing this form.