AUTHORIZATION TO OBTAIN INFORMATION FROM OUTSIDE HEALTH CARE PROVIDERS

Patient Name: _____

Date of Birth: _____ Medical Record Number: _____

I, the undersigned, hereby authorize:

_____

Name of Physician or Facility to Release Health Information

_____

Physician or Facility Street Address

_____ _____

City, State Zip Code

_____ _____

Telephone Fax Number

To be released to:

☐UCR Health Women's Health – 19330 Jesse Ln, Suite 100, Riverside, CA 92508

☐UCR Health Neurosurgery – 4510 Brockton Ave, Suite 365, Riverside, CA 92501

☐UCR Health Neurology– 3390 University Ave, Suite 100, Riverside, CA 92501

☐UCR Health Pain Management – 3390 University Ave, Suite 100, Riverside, CA 92501

☐UCR Health Psychiatry – 3390 University Ave, Suite 115, Riverside, CA 92501

☐UCR Health Psychiatry – 18881 Von Karman, Suite 1227, Irvine, CA 92612

☐UCR Health Plastic and Reconstructive Surgery – 3390 University Ave, Suite 100, Riverside, CA 92501

Information to be RELEASED: Specify the dates for information selected below:

☐ Discharge Summary	☐ Laboratory Reports	☐ Emergency Medicine Reports
☐ History and Physical Exams	☐ Pathology Reports	☐ Operative Reports
☐ Diagnostic Imaging Reports	☐ Progress Notes	☐ Consultations
☐ Radiology Reports	☐ Outpatient Clinic Records	☐ EKG Studies

☐Other: _____

SPECIFIC AUTHORIZATIONS:

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

☐ 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).

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

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

☐ 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/or payment of bill

☐ At the request of the patient or patients authorized representative

☐ Other (state reason): _____

NOTICE

UCR Health 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 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, provided that I do so in writing and submit it to UCR Health, School of Medicine, 14350-2 Meridian Parkway, Riverside, CA 92518. The revocation will take effect when UCR Health receives it, except to the extent that UCR Health or others have already relied on it.

I am entitled to receive a copy of this authorization.

EXPIRATION OF AUTHORIZATION

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

PERSONAL USE

I understand I may be charged a per page fee for copies produced for my personal use. _____ (Initial)

SIGNATURE

_____

Signature of patient or patient's legal representative

_____ _____ AM/PM

Date Time

_____

Printed Name

_____

Relationship if signed by someone other than the patient (Witness/Translator)