UCI Medical Center
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Medical Record Number:

Patient Name:
Date of Birth:

I authorize UCI Medical Center to release health information to:

____
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

____
Phone number

INFORMATION TO BE RELEASED

- ☐ Discharge Summary
- ☐ Billing Statements
- ☐ Pathology Reports
- ☐ EKG
- ☐ Progress Notes
- ☐ Laboratory Reports
- ☐ Dental Records
- ☐ Operative Reports
- ☐ Radiology Reports
- ☐ Emergency Medicine Reports
- ☐ History & Physical Exams
- ☐ Diagnostic Imaging Reports
- ☐ Consultations
- ☐ Outpatient Clinic Records

☐ Other ______________________________

SPECIFY THE DATE OR TIME PERIOD FOR INFORMATION SELECTED ABOVE

____

SPECIFIC AUTHORIZATIONS

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

Authorized Agent:
Knox Attorney Service, Inc./ Knox Services LLC.

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)____

NOTICE

UCIMC 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) obtaining information in connection with eligibility or enrollment in a health plan for 3) determining an entity's obligation to pay a claim, or 4) creating health information to provide to 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 UCIMC c/o Health Information Management, Rt. 118, Bldg.25, Orange, CA 92868. The revocation will take effect when UCIMC receives it, except to the extent that UCIMC 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 expires ______________*(insert applicable date or event). If no date is indicated, this authorization will expire 12 months after the date of signing this form.*

SIGNATURE

______________________________________ Date: ________________

(Signature of Patient or Patient's Legal Representative)

____ Time: _______ AM / PM

Printed Name

____

(If signed by someone other than the patient, state your legal Relationship to the patient/authority)

____

Witness or Translator

Form 81610
(Rev. 04/03)

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