UCSD *Healthcare*

Name

MR#

DOB

Source Date

Patient Identification

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 ❒ Mental Health (other than psychotherapy notes)

INFORMATION TO BE RELEASED

❒ Billing Statements
❒ Consultations/Evaluations
❒ Dental Records
❒ Discharge Summary
❒ Drug and Alcohol Abuse Information
❒ EKG
❒ Emergency Medicine Reports
❒ Genetic Testing Information
❒ History & Physical Exams
❒ HIV/AIDS Test Results
❒ Laboratory Reports
❒ Operative Reports
❒ Outpatient Clinic Records
❒ Pathology Reports
❒ Progress Notes
❒ Psychological/Vocational Test Results
❒ Radiological and other Diagnostic Images (X-Rays, etc)
❒ Radiology and other Diagnostic reports

❒ Other ______________________________

SPECIFY THE DATE OR TIME PERIOD FOR INFORMATION SELECTED ABOVE

____

D818(4-03)

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

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

- ❒ At the request of the patient/patient representative
- ❒ Other (state reason) ______________________________

Notice

UCSD Healthcare 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 I do so in writing and submit it to:

  Health Information Services
  UCSD Healthcare
  200 W. Arbor Drive, #8825
  San Diego, CA 92103-8825

- The revocation will take effect when UCSD Healthcare receives it, except to the extent that UCSD Healthcare 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[1] on: ______________________
(Insert applicable date or event)

Signature

______________________________ Date: __________________
(Signature of Patient or Patient's Legal Representative)

______________________________ Time: _______ AM / PM
(Printed Name)

____
Relationship to patient (if other than patient):

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

(Footnotes)
[1] *If no date is indicated, this Authorization will expire 12 months after the date of signing this form.*