



Send Records to: All Clinic Contact Number: (844) 827-8000

- Airport Towers / Citrus Towers - Psychiatry Fax: (951) 263-7238
Citrus Towers - Multispecialty Fax: (951) 344-5362
Riverbrock - Neurosurgery Fax: (951) 402-2803
Silver Oaks - Women's Health Fax: (951) 263-7237

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ MRN: \_\_\_\_\_

I, the undersigned, hereby authorize:

Name of Physician or Facility to Release Health Information Telephone Number

Physician or Facility Street Address Fax Number

The purpose of this release is:

- Continuity of Care or Discharge Planning Other

Effective Period:

Last Office Visit or (month/year) to (month/year)

Information to be Released:

- Complete Medical Record (Excluding Billing Records) Operative Report
Complete Medical Record (Including Billing Records) Radiology Report(s)
Clinic Visit Note Laboratory Report EKG CT Scan
Consultation Vaccinations/Immunizations MRI X-Ray
Other:

Specific Authorization:

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 abuse diagnosis or treatment.
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))



**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, do so in writing and submit it to UCR Health Compliance 13450-2 Meridian Pkwy, 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, 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: \_\_\_\_\_

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

**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.