Patient Label

Authorization to Obtain Information From Outside Health Care Providers

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

☐ **Airport Towers / Citrus Towers - Psychiatry** **Fax: (951) 263-7238**
- ☐ Airport Towers – 1888 Van Karman Ave. Irvine, CA 92612
- ☐ Citrus Towers – 3390 University Ave., Ste115 Riverside, CA 92501

☐ **Citrus Towers - Multispecialty** **Fax:** _____
3390 University Ave., Ste 100 Riverside, CA 92501

☐ **Riverbrock - Neurosurgery** **Fax: (951) 402-2803**
4510 Brockton Ave. Ste 365 Riverside, CA 92501

☐ **Silver Oaks – Women's Health** **Fax: (951) 263-7237**
19330 Jesse Lane, Ste 100 Riverside, CA 92508

☐ **La Quinta – Pediatrics & Family Medicine**
79430 Highway 111, Ste 102 La Quinta, CA 92253 **Fax: (760) 400-9971**

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 ☐ Personal Use ☐ Other_____

Effective Period:
☐ Last Office Visit **or** ☐ _____(month/year) to _____(month/year)

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

Specific Authorization: The following information will not be released unless you specifically authorize it by initialing and marking the relevant box(es) below:

_____ Initial ☐ I specifically authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment.

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

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

_____ Initial ☐ I specifically authorize the release of genetic testing information (Health and Safety Code 124980(j))

UCR HEALTH

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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.