

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ DOB: _____ Chart# _____

SID # _____ Phone # _____

Address _____

Street City, State Zip

I authorize:

(Name of person/facility which has information)

Street address, City, State, Zip Code

Phone _____ Fax _____

to release health information to:

(Name of person/facility to receive information)

Street address, City, State, Zip Code

Phone _____ Fax _____

TYPE OF DISCLOSURE: (check) Copies Verbal Inspection Summary

PLEASE SPECIFY THE HEALTH INFORMATION YOU AUTHORIZE TO BE RELEASED:

- MEDICAL** (may include drug/alcohol /mental health info documented by a primary care provider.)
- MENTAL HEALTH** (include psychiatric/mental health notes documented in the CSHC medical record)

DATE(s) of treatment or time period: _____

TYPE(s) of health information:

- Immunizations/vaccinations
- other (specify) _____

If applicable please check:

- I specifically authorize the release of **HIV/AIDS test results**
(Health and Safety Code 120980(g)).
- 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 **genetic testing** information
(Health and Safety Code 124980(j)).

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

- At the request of the patient or patient representative
- Other (state reason)_____

PERSONAL COPIES: _____ (initial) I understand I may be charged a reasonable fee for copies

NOTICE

UCD CSHC 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.

YOUR RIGHTS

This authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct 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.

This authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to: Medical Record Supervisor, CSHC, UCD, One Shields Avenue, Davis, CA 95616.

The revocation will take effect when UCD CSHC receives it, except to the extent UCD CSHC or others have already relied on it.

You are entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION

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

Print Name

Signature (Patient/Patient representative)

Date

Time

Witness