

**Patient Name:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_  
**Patient Address:** \_\_\_\_\_  
Street  
**City**                    **State**                    **Zip Code**  
**Phone Number:** \_\_\_\_\_

UNIVERSITY of CALIFORNIA, IRVINE - HEALTHCARE  
**Authorization for Release  
of Health Information**  
  
**Medical  
Record Number:** \_\_\_\_\_

I authorize UC Irvine Healthcare 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**

<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Emergency Medicine Reports
<input type="checkbox"/> Billing Statements	<input type="checkbox"/> Dental Records	<input type="checkbox"/> History & Physical Exams
<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Diagnostic Imaging Reports
<input type="checkbox"/> EKG <input type="checkbox"/> Progress Notes <input type="checkbox"/> Vaccinations/Immunizations	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Consultations <input type="checkbox"/> Outpatient Clinic Records
<input type="checkbox"/> 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)).

**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 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 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.*

**PERSONAL USE**

I understand I will be charged a per page fee for copies produced for my personal use.

\_\_\_\_\_  
Initial

**SIGNATURE**

\_\_\_\_\_  
(Signature of Patient or Patient's Legal Representative)

Date: \_\_\_\_\_

Time: \_\_\_\_\_ AM/PM

\_\_\_\_\_  
Printed Name

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

\_\_\_\_\_  
Witness or Translator

Mail form with original signature to:  
UC Irvine Healthcare  
Health Information Management  
Building 25, Route 118  
101 The City Drive South  
Orange, California 92868  
(714) 456-5670