UC Irvine Health

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, _____authorize the following persons:
Print name of individual

UC Irvine Well Being Committee & Committee Chair, Dr. Brian Smith and my treating physician(s)/practitioners

To release and exchange between parties the medical information of:

NAME: _____ BIRTHDATE: _____
Print name of individual
ADDRESS: _____
Street Address, City, State, Zip Code
MRN: _____

To:

1. Name: _UC Irvine Well Being Committee_ Affiliation: _____

Phone: _____ Fax: _____

2. Name: _____ Affiliation: _____

Phone: _____ Fax: _____

3. Name: _____ Affiliation: _____

Phone: _____ Fax: _____

4. Name: _____ Affiliation: _____

Phone: _____ Fax: _____

Please specify the health information you authorize to be released:

☑ MEDICAL

☑ Discharge Summary
☑ History & Physical Exams
☑ Outpatient Clinic Records
☑ Progress Notes
☑ Emergency Medicine Reports

☑ MENTAL HEALTH (other than psychotherapy notes)

☑ Laboratory Reports
☑ Consultations/Evaluations
☑ Drug & Alcohol Abuse Information
☑ Psychological/Vocational Test Results

Purpose of this release: For the participation in the UC Irvine Well Being Program.

Specify the date or time period for information selected above: _____

☑ 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).

NOTICE: UC Irvine 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. **In the event of a subpoena, the Medical Staff Health Committee may be required to release documents pertaining to committee activity.**

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.

I may revoke this authorization at any time, provided that I do so in writing and submit it to the UC Irvine Well Being Committee. The revocation will take effect when the UC Irvine Well Being Committee receives it.

I am entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION: Until revoked by you, this authorization will expire ten years from the date identified below.

_____ _____

Signature of Individual Date