Patient Name: _____

DOB: _____

MRN: _____

UCI Health

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION *Please Print Clearly*

_____
Patient Last Name First Middle Initial

_____
Address City State Zip Code

____/____/_____ (_____)_____-_____
Date of Birth Telephone

SELECT HEALTHCARE FACILITY

☐ UCI Health Hospitals/Clinics ☐ UCI Neuropsychiatric (NPH) ☐ Other: _____

I authorize **UCI Health** to release my medical records to:

_____
Name of Hospital/Clinic/Person

_____
Address City State Zip Code

(_____)_____-_____ (_____)_____-_____
Telephone Fax

If you would like a designee* to pick up your medical records, please fill out section below:

I authorize _____ to pick up copies of my medical record.

Relationship to patient: _____ ***Note:** Designee must provide valid photo ID

DELIVERY INSTRUCTIONS *Please select one*

☐ CD ☐ myUCIhealth (MyChart) ☐ Paper copy

☐ Email (sensitive information is not released via email)

Email address: _____@_____

☐ I authorize the use of encrypted email to communicate with me

☐ I authorize the use of unencrypted email to communicate with me

For email delivery: According to the California law, your provider may not communicate any lab results unless your email correspondence is conducted through a secure server. Additionally, email must never be used for results of testing related to HIV, sexually transmitted disease, hepatitis, drug abuse or presence of malignancy, or for alcohol abuse or mental health issues.

UC Irvine Health is not responsible for email messages that are lost due to technical failure during composition, transmission and/or storage.

I understand that UC Irvine Health has a secure messaging system for communication with patients. However, I would like to communicate with my provider via email. I have read and understand the information above and I had any questions answered to my satisfaction. I agree to the above guidelines for email communication.

Patient Name: _____

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UCI Health

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PURPOSE *What is the purpose of this release?*

☐ Patient/patient representative request

☐ Other (state reason): _____

Limitations, if any: _____

INFORMATION TO BE RELEASED *What records are being requested?*

☐ Billing Statement	☐ Emergency Report	☐ Pathology Report
☐ Consultation	☐ History and Physical	☐ Progress Note
☐ Covid Card	☐ Immunization Record	☐ Radiology Image
☐ Discharge Summary	☐ Laboratory Report	☐ TeleDoc (UCI on-call virtual visit)
☐ EKG	☐ Operative Report	☐ All

☐ Other: _____

SPECIFY DATES OR TIME PERIOD FOR INFORMATION SELECTED

From: ____/____/_____ To: ____/____/_____
MM/DD/YYYY MM/DD/YYYY

SENSITIVE INFORMATION

Sensitive information will <u>not</u> be released unless specifically authorized below:

☐ Abortion or abortion related services ☐ Drug and Alcohol Abuse Results

☐ Genetic testing information ☐ HIV/AIDS test results ☐ Psychological/Vocational Results

EXPIRATION OF AUTHORIZATION *(insert applicable date or event)*

Unless otherwise revoked, this authorization expires: _____

Authorization will expire 12 months after the date signed.

SIGNATURE(S)

_____ _____
Signature of Patient/Legal Representative Date

_____ (_____)_____
Printed Name Telephone

If signed by someone other than the patient, indicate relationship to the patient:

_____

_____ _____
Signature of Witness (only if patient is unable to sign) or Interpreter Date

Interpreter ID #: _____ Language: _____

Patient Name: _____

DOB: _____

MRN: _____

UCI Health

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

CONTACT RELEASE OF INFORMATION

UCI Health
Release of Information
101 The City Drive, Building 25A
Route 118
Orange, CA 92868 (714) 456-5670 - Press Option 5 then Option 1 Fax: (888) 522-3679
Email: roi@hs.uci.edu TDD: (714) 456-5670 Ext: 711

For information to obtain medical records via myUCIhealth visit our website:
https://my.ucihealth.org/ For assistance, call (833) 469-2478

COMPLETING AUTHORIZATION TO RELEASE MEDICAL RECORDS

To protect our patient's confidential medical records, we must have a valid, complete and legible authorization to disclose their medical records.

All sections of this authorization must be completely filled out before UCI Health is permitted to disclose your protected medical records.

NOTICE

Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

REVOCATION

I may revoke this authorization at any time, provided that I do so in writing and submit it to:
UCI Health
101 The City Drive, Building 25A
Orange, CA 92868
(714) 456-5670 | Fax: (888) 522-3679

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

MY RIGHTS

I understand this authorization is voluntary. Treatment, payment enrollment, or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for:

- Conducting research-related treatment
- Obtaining information in connection with eligibility or enrollment in a health plan
- Determining an entity's obligation to pay a claim
- Creating protected health information to provide to a third party

I am entitled to receive a copy of this authorization.

Requesting records using the UCI Health patient portal is available for patients and their proxies. Visit myUCIhealth at: https://my.ucihealth.org/ or call (833) 469-2478 for more information.