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 – Orange ☐ UCI Health – Fountain Valley ☐ UCI Health – Lakewood
☐ UCI Health – Irvine ☐ UCI Health – Los Alamitos ☐ UCI Health – Placentia Linda
☐ UCI Neuropsychiatric (NPH) ☐ Ambulatory: _____
☐ Other: _____

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

_____
Name of Hospital/Clinic/Person

_____
Address City State Zip Code

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

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

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

SPECIFY DATES OR TIME PERIOD FOR INFORMATION SELECTED

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

SENSITIVE INFORMATION

Sensitive information will not be released unless specifically authorized below:

☐ Abortion or abortion related services ☐ Gender-affirming healthcare
☐ Drug and alcohol abuse results ☐ Genetic testing information
☐ HIV/AIDS test results ☐ Psychological/vocational results

Patient Name: _____

DOB: _____

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UCI Health

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

DELIVERY INSTRUCTIONS *Please select one*

☐ 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

☐ 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.

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

I understand that UCI 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.

PURPOSE *What is the purpose of this release?*

☐ Patient/patient representative request ☐ Other (state reason): _____

Limitations, if any: _____

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

Unless otherwise revoked, this authorization expires: _____
Authorization will expire 12 months after the date signed.

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 ☐ Please provide copy

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.

Patient Name: _____

DOB: _____

MRN: _____

UCI Health

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

REVOCATION

I may revoke this authorization at any time, provided that I do so in writing and submit it to:

UCI Health – Orange 101 The City Drive, Building 25A Orange, CA 92868	(714) 456-5670 | Fax: (888) 522-3679
UCI Health – Fountain Valley 11170 Warner Ave, Suite 102 Fountain Valley, CA 92708	(714) 966-8027 Option 1 | Fax: (714) 966-3367, (714) 966-3352
UCI Health – Los Alamitos Release of Information 3951 Katella Ave Los Alamitos, CA 90720	(562) 799-3246, (562) 799-3256 | Fax: (562) 799-3225
UCI Health – Lakewood Medical Records 3700 E South St Lakewood, CA 90712	(562) 602-6790 | Fax: (562) 602-6779
UCI Health – Placentia Linda Medical Records 1301 Rose Drive Placentia, CA 92870	(714) 524-4846 | Fax: (714) 524-4867

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

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.

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

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.

CONTACT RELEASE OF INFORMATION

UCI Health – Orange Release of Information Building 25A 101 The City Drive, 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
UCI Health – Fountain Valley Release of Information 11170 Warner Ave, Suite 102 Fountain Valley, CA 92708 (714) 966-8027 Option 1 | Fax: (714) 966-3367, (714) 966-3352 Email: fvrroi@hs.uci.edu
UCI Health – Los Alamitos Release of Information 3951 Katella Ave Los Alamitos, CA 90720 (562) 799-3246, (562) 799-3256 | Fax: (562) 799-3225 Email: LAMCROI@hs.uci.edu
UCI Health – Lakewood Release of Information 3700 E South St Lakewood, CA 90712 (562) 602-6790 | Fax: (562) 602-6779
UCI Health – Placentia Linda Health Information Services 1301 Rose Drive Placentia, CA 92870 (714) 524-4846 | Fax: (714) 961-5980 Email: upla@hs.uci.edu

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