Patient Label

UCI Health

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Information	Patient Name:	MF	RN:	
Illiorillation	Address:			
		Ph		
	Date of Birth (MMDDYY)	YY):Last 4	of SS#	
Specify Healthcare Facility	□ UCI Health Hospitals/0□ UCI Neuropsychiatric□ Other	Clinics		
Release Records to	I authorize UCI Health to release my PHI to:			
Where do	Name of Hospital/Clinic/Person:			
you want	Address:			
records sent?	City, State & Zip Code:			
	Phone: ()	FAX: ()		
	*E-Mail Address:			
Who do you	*Note: Please provide your email address to receive an email status of your request.			
want to	If you would like a designee** to pick up your records, please fill out section below:			
receive	ceive cords? I authorizeto pick up my medical record copies. Relationship to patient:			
records?				
Delivery	**Note: Designee must provide valid photo ID CD E-Mail (NPH does not release via email) Call Requestor when records are ready for pick up myUClhealth (Mychar			
Instructions (please				
select <u>one</u>)	Note: If left blank, a CD will be provided.			
Purpose What is the	☐ At the request of the patient/patient representative			
purpose of	☐ Other (state reason):			
this release?	Type of December			
Health Information	Type of Records: ☐ Billing Statements	☐ Emergency Reports (ER)	☐ Pathology Reports	
to be	☐ Consultations	☐ History & Physical Exams	37 1	
Released: What	☐ Covid replacement card		☐ Radiology Images	
records are being	☐ Discharge Summary	□ Laboratory Reports	☐ TeleDoc (UCI oncall	
	□EKG	□ Operative Reports	virtual visit)	
requested?	□ Other	•	1	

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Sensitive Information	Sensitive information will not be released unless specifically authorized below:			
	□ Drug and Alcohol Abuse Results□ HIV/AIDS Test Results□ Psychology	c Testing Information blogical/Vocational Results		
Specify	SPECIFY DATE / TIME PERIOD FOR INFORMATION SELECTED ABOV			
Date/Time Period	FROM TO			
Expiration of Authorization	Unless otherwise revoked, this Authorization expires			
Signature(s)	(Signature of Patient / Legal Representative)	Date		
	Printed Name	Area Code/Phone Number		
	If signed by someone other than the patient, i patient	ndicate relationship to the		
	Signature of Witness (only if patient unable to sign) or Interpreter	Date Interpreter ID #		

Mailing Addresses

UCI Health- Release of Information

101 The City Drive, Building 25A

Route 118

Orange, CA 92868 Fax: (888) 522-3679 Phone: (714) 456-5670

Press Option 5, then Option 1

Email: roi@hs.uci.edu

Request medical records via myUClhealth Visit our website for information: https://www.my.ucihealth.org
Call for Assistance: 833-469-2478

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COMPLETING AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

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

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

Notice

UCI Health 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.

Revocation

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

UCI Health

101 The City Drive. Building 25A

Orange, CA 92868

Fax: (888) 522-3679 | Phone: (714) 456-5670

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:

- 1) Conducting research-related treatment.
- 2) Obtaining information in connection with eligibility or enrollment in a health plan.
- 3) Determining an entity's obligation to pay a claim.
- 4) Creating PHI 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 myUClhealth at: https://www.my.ucihealth.org or call (833) 469-2478 for more information.

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