PATIENT NAME_____

MEDICAL RECORD #:_____

BIRTHDATE:_____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize: _____
Name of person and/or facility which has information

_____
Street Address, City, State, Zip Code

to release health information to:

c/o Appleby & Company, Inc

Specify name/title of person and/or facility to receive health information

Street Address, City, State, Zip Code

****

Please specify the health information you authorize to be released:

❒ MEDICAL

❒ MENTAL HEALTH (other than psychotherapy notes)

Type(s) of health information: _____

Date(s) of treatment:_____

You may also authorize the release of information for treatment provided after the date of the signature on this Authorization as long as such treatment occurs while this authorization has not expired. Please initial if you would like this Authorization to release information about healthcare you receive after the date of your signature. _____
(Initial here)

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 HIV/AIDS test results (Health and Safety Code §120980(g)).

❒ I specifically authorize the release of genetic testing information (Health and Safety Code §124980(j)).

PATIENT NAME_____

MEDICAL RECORD #:_____

BIRTHDATE:_____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

The purpose of this release is for (check one or more):

❒ At the request of the patient/patient representative

❒ Other (state reason) _____

NOTICE

UCDHS 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.

YOUR 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.

This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to: Health Information Management Department, UCDHS, 2315 Stockton Blvd., Building 12, Sacramento, California 95817.

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

You are 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, the Authorization will expire 12 months after the date of my signing this form.

_____ _____

Print Name | Signature (Patient, Parent, Representative)

_____ _____

Date Time | Relationship to Patient (Parent, Guardian, Conservator, Patient Representative)

_____

Witness (only if patient unable to sign) or Interpreter