

Name

MR#

DOB

Source

Date

Patient Identification

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

I authorize \_\_\_\_\_ to release health information to:  
(Name of person or facility, which has information)

\_\_\_\_\_  
Name of person or facility to receive health information

\_\_\_\_\_  
Specify name/title of person to receive health information, if known

\_\_\_\_\_  
Street Address, City, State, Zip Code

( \_\_\_\_\_ ) \_\_\_\_\_ Extension: \_\_\_\_\_  
Telephone Number

***TYPE OF RECORD***

- Medical
- Mental Health (other than psychotherapy notes)

***INFORMATION TO BE RELEASED***

- Billing Statements
- Emergency Medicine Reports
- Outpatient Clinic Records
- Consultations/Evaluations
- Genetic Testing Information
- Pathology Reports
- Dental Records
- History & Physical Exams
- Progress Notes
- Discharge Summary
- HIV/AIDS Test Results
- Psychological/Vocational Test Results
- Drug and Alcohol Abuse Information
- Laboratory Reports
- Radiological and other Diagnostic Images (X-Rays, etc)
- Operative Reports
- EKG
- Radiology and other Diagnostic reports

Other \_\_\_\_\_

***SPECIFY THE DATE OR TIME PERIOD FOR INFORMATION SELECTED ABOVE***

\_\_\_\_\_

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

- At the request of the patient/patient representative
- Other (state reason) \_\_\_\_\_

*Notice*

UCSD Healthcare 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.

*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) 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 I do so in writing and submit it to:

Health Information Services  
 UCSD Healthcare  
 200 W. Arbor Drive, #8825  
 San Diego, CA 92103-8825

- The revocation will take effect when UCSD Healthcare receives it, except to the extent that UCSD Healthcare or others have already relied on it.
- I am entitled to receive a copy of this Authorization.

*Expiration of Authorization*

Unless otherwise revoked, this Authorization expires<sup>1</sup> on: \_\_\_\_\_  
(Insert applicable date or event)

*Signature*

\_\_\_\_\_  
 (Signature of Patient or Patient's Legal Representative)

Date: \_\_\_\_\_

\_\_\_\_\_  
 (Printed Name)

Time: \_\_\_\_\_ AM / PM

\_\_\_\_\_  
 Relationship to patient (if other than patient):

(Footnotes)

<sup>1</sup> If no date is indicated, this Authorization will expire 12 months after the date of signing this form.