



# UC San Diego

## MEDICAL CENTER

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_

MR# \_\_\_\_\_

### 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                       Billing                       Radiology images (X-rays, etc.)

**INFORMATION TO BE RELEASED**

- Inpatient dictated records (Discharge summary, History & Physical, Progress notes, operative reports, consultations, laboratory, radiology, and other diagnostic reports)
- Outpatient dictated records (Office notes, consultations, operative reports, laboratory, radiology, and other diagnostic reports)
- Immunization Records
- Emergency Department Reports

**Sensitive Information**

- HIV Test Results \_\_\_\_\_  Genetic Test Results \_\_\_\_\_
- Patient initials                      Patient initials
- Psychiatric treatment records \_\_\_\_\_
- Patient initials
- Drug & alcohol abuse treatment records \_\_\_\_\_
- Patient initials

**SPECIFY THE APPROXIMATE DATES OF TREATMENT FOR INFORMATION SELECTED:**

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# UC San Diego MEDICAL CENTER

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Identification

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

- Continuing medical care   
  Inspection of record   
  Insurance  
 Legal matter   
  Personal copy   
  Other

### Notice

UC San Diego Medical Center 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 that I do so in writing and submit it to:  
 UC San Diego Medical Center  
 Health Information Services  
 200 W. Arbor Drive, # 8825  
 San Diego, CA 92103-8825
- The revocation will take effect when UCSD Medical Center receives it, except to the extent that UCSD Medical Center 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.