University of California, Riverside, Campus Health Center (CHC), Riverside, CA 92521
Tel (951) 827-3031, Fax (951) 827-3133

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient: _____ Birth Date: _____ ID#_____

I authorize the person/facility, which has the health information

_____

Name/facility Telephone # Fax #

_____

Address City State Zip Code

to release the health information to: self ( ) facility ( ) provider ( ) Other ( )

_____

Name/facility Telephone # Fax #

_____

Address City State Zip Code

Please specify the health information you are authorizing to be released:

X-Ray Results ( ) Lab Results ( ) Clinical Notes ( ) All Records ( ) Mental Health Records ( )

Other type(s) of health information: _____

Specify date(s) of treatment or time period: _____

The following information will not be released unless you specifically authorize it by initialing the appropriate line(s):

____ I authorize the release of information about drug and/or alcohol abuse, diagnosis or treatment (42 C.F.R. §§ 2.34 & 2.35)

____ I specifically authorize the release of HIV/AIDS test results. (Health and Safety Code §120980 (g))

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

____ Requested by patient/patient representative ____ Other (state reason)_____

EXPIRATION OF AUTHORIZATION: Unless otherwise revoked, this Authorization expires on _____. If no date is indicated, the Authorization will expire 12 months after the date of signing this form.

SIGNATURE (Before signing, please read important information on back, then initial here _____)

_____

Print Name Signature (Patient or Patient Representative) Date/Time

_____ _____

Relationship to Patient Telephone Number

Staff Use Only: ( ) Mailed ( ) Hand Carried ( ) Faxed Staff Initial_____ Provider's Initial_____ Date_____

NOTICE: CHC 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, state or federal confidentiality laws may no longer protect it.

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: **University of California, Riverside, Campus Health Center, Riverside, CA 92521.** The revocation will take effect when CHC receives it, except to the extent CHC or others have already relied on it.
You are entitled to receive a copy of this Authorization.