UC San Diego Health

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

***Hospital & Clinic staff:**
Affix patient label here. If providing records to the patient, update the Staff Use section of the form and update Quick Disclosure.

Patient Identification

Patient Information:	Patient Name		Nickname/Maiden/Other
	Address/City/State/Zip		
	Date of Birth	Last 4 of SSN#	Phone
	_____ / _____ / _____		
Record Holder: *Who has the information you want released?*	☐ UC San Diego Health ☐ Other: _____		
	Address/City/State/Zip		
	Phone	Fax (Urgent Patient Care only)	
Release Records to: *Where do you want records sent? Who do you want to receive records?*	Name of Hospital/Clinic/Persion		
	Street Address/City/State/Zip		
	Phone	Fax (Urgent Patient Care only)	
Purpose:	☐ Continued Care – Appointment Date (if known): _____ / _____ / _____ ☐ Legal ☐ Personal ☐ Insurance ☐ Disability Other *(please specify):*		
Health Information to be Released: *What do you want sent or released?*	Routine Record Sets – **For dates of service:** _____ ☐ **Hospital Stay** (History and physical, operative report, discharge summary, progress notes, lab, radiology reports) ☐ **Clinic visit** (office notes, procedure notes, operative notes, lab, diagnostic and radiology results) ☐ **Other Records –** *Please Specify Type:* _____ ☐ **Billing Records** ☐ **Radiology Images (only)** ☐ Mail ☐ Pick-up ☐ Email** (See bottom of page 2 for email limitation)		
Sensitive Information:	**Sensitive information WILL BE RELEASED unless you tell us not to by initialing below:** _____ Do Not Release Drug & Alcohol abuse treatment records _____ Do Not Release Mental Health/Psychiatric treatment records _____ Do Not Release HIV Test Results _____ Do Not Release Genetic Test Results		
Authorization	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 understand this authorization may be revoked in writing at any time except to the extent that action had been taken in reliance on this authorization. Unless otherwise revoked this authorization will expire 12 months after the date of signing this form.		

Signature of Patient or Authorized Representative	Print Name	Date	Time
			AM/PM

Relationship (If signed by other than Patient)	If Interpreted: Signature OR ID of Interpreter ☐ Telephone ☐ Video	Language	Date	Time
				AM/PM

***Staff Use**	Info Released By: On Date:

UC San Diego Health

COMPLETING AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

***Hospital & Clinic staff:** Affix patient label inside this box and indicate if records have been provided to the patient in the Staff Use section at the bottom of the form.

Patient Identification

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 UC San Diego Health is permitted to disclose your protected health information.

Notice:
UC San Diego 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:
A revocation/cancellation of this authorization can be provided at any time in writing to:

UC San Diego Health
Shiley Eye Institute
9415 Campus Point Drive
La Jolla, CA 92093-0946

Patient's rights:
Under California Health and Safety Code any adult patient, a minor patient authorized by law to consent to his or her own treatment, or the patient's legal representative, (i.e., a parent, guardian, conservator, or personal representative of a deceased patient) has a right to access the clinical record. As per Section 123110, if the patient or representative requests to inspect the record, the request to inspect must be in writing and the record must be made available during regular business hours within five (5) working days after the request is received. If the patient wants a copy of all or part of the record, the request for copies must be in writing, and copies must be provided within fifteen (15) days after receiving the request. Under the code, providers may recover up to $0.25 per page for the cost of copying the record, as well as, the reasonable cost for locating the record and making the record available.

Medical Record Fees:
There is no charge for records to be sent to another health care provider. Records released directly to the patient or an authorized family member may be subject to charges; the first 20 pages are at no cost and after the 20th page there will be charge of $0.25 per page.

Radiology Image Fees:
The first copy is free of charge, $25.00 due for each additional copy unless for a provider.

**PLEASE NOTE: Only the three (3) most recent studies can be mailed electronically (email).