UC San Diego Health

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Mailing Address: UC San Diego Health, Attn: Health Information Management
200 West Arbor Drive, #8825, San Diego, CA 92103
Fax: 619-543-7128

***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/Person		
	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:** _____ ☐ **Emergency Room Visit** (ED provider notes, radiology, lab and diagnostic, consults, and procedure notes) ☐ **Hospital Stay** (History and physical, consult, operative report, discharge summary, lab and radiology reports) ☐ **Clinic or Office Visit** (Progress notes, office notes, procedure notes, operative notes, lab, diagnostic and radiology results) ☐ **Other Records –** *Please Specify Type:* _____ ☐ **Billing Records** ☐ **Radiology Images (only)** Delivery Method *(please select one):* ☐ Mail ☐ Pick-up ☐ MyChart ☐ Email: _____****** (See bottom of page 2 for email limitation)		
Sensitive Information:	**Sensitive information <u>WILL NOT BE RELEASED</u> unless you initial below:** _____ Release Drug and Alcohol abuse treatment records _____ Release Mental Health/Psychiatric treatment records _____ Release HIV Test Results _____ Release Gender-affirming records _____ Release Genetic Test Results _____ Release Contraception records _____ Release Abortion care-related records		

UC San Diego Health

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

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.

_____	_____	_____	_____	AM/PM
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	Language ☐ Telephone	Date ☐ Video	Time

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

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, Attn: Health Information Management
200 W Arbor Drive, #8825, San Diego, CA 92103-8825

Patient's rights: Under California Health and Safety Code any adult patient, a minor patient authorized by law to consent to their 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. Fees cap at $6.50 per request.

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).