RESET PRINT

PATIENT NAME: _____
DATE OF BIRTH: _____
UC Davis Health MEDICAL RECORD #: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone #: _____
Email (recommended): _____

UC DAVIS HEALTH
SACRAMENTO, CALIFORNIA

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

☐ *Verbal Communication Only (For Internal Use)*

I hereby authorize:	To release health information to:
Name of person / facility to release health information	Name of person / facility to receive health information
Street Address, City, State, Zip Code	Street Address, City, State, Zip Code

Type(s) of Health Information to be Released for the following date range: _____ to _____

☐ Medical Records ☐ Radiology Images ☐ Billing Records ☐ Other: _____

☐ Records limited to the following provider(s) or department(s): _____

I further authorize the release of information for treatment provided after the date of signature on this authorization, as long as such treatment occurs while this authorization has not expired. _____ (initials)

The information below is protected by law and will not be released unless you specifically authorize:	
☐ Mental Health (other than psychotherapy notes) For psychotherapy notes, complete the psychotherapy authorization form.	☐ HIV Test Results
☐ Drug/Alcohol Abuse Treatment Records	☐ Genetic Testing Information

Release Delivery Options (select one):			
US Mail	Electronically	Fax	On-Site Inspection
☐ Paper ☐ CD	☐ Secured Email ☐ MyUCDavisHealth	☐ Fax (continuation of care only) *Fax #* _____ - _____ - _____	☐ Paper Chart

The purpose of this release is for: ☐ Patient/Patient Representative ☐ Other: _____

Notice: Fees may apply for copies of your records. Unless required by law, California law prohibits the recipient from further disclosing your health information unless the recipient obtains another authorization from you. 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.

Your Rights: This authorization to release health information in voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this form. You may revoke this authorization at any time. The revocation must be in writing, signed by you or your patient representative, and mail to: UC Davis Health, Health Information Management, 2315 Stockton Blvd., Sacramento, CA 95817. The revocation will take effect when UC Davis Health receives it, except to the extent UC Davis Health or others have already relied on it. A copy of this authorization is valid as the original. You are entitled to receive a copy of this authorization.

Expiration of Authorization: Unless otherwise revoked, this authorization expires _____ (insert date). If no date is indicated, the authorization will expire 12 months after the date of my signing this form.

Date	Print Name	Patient / Patient Rep Signature	Relationship to Patient

Interpreter Signature, if applicable