AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Print in ink ◆ Failure to provide all information may invalidate this authorization

From Whom Specify clinic, hospital, or physician below

☐ Loma Linda University Medical Center - Murrieta

☐ Specify: _____

To Whom/Inspect Individual/Agency Name

☐ Send records to: _____

_____

Address City State Zip Code

☐ Make records available for review. Confirm appointment prior to review.

Information to be Released

Specify where services were rendered (Location) _____

☐ Inpatient Dates of Treatment _____

☐ Discharge Summary / Standard Clinical Pertinent Documents

☐ Other, Specify _____

☐ Outpatient Dates of Treatment _____

☐ Clinical Notes ☐ Test Results, type of test _____

☐ Other, Specify _____

☐ I specifically authorize release of: ☐ HIV test results ☐ Psychiatric Records ☐ Substance Abuse Records

☐ Billing Summary Dates of Treatment _____

PURPOSE Reasons records are to be disclosed

☐ Continued Care ☐ Personal Use ☐ Other, Specify _____

Unless otherwise revoked, this authorization will expire on the following date, event or condition _____. This authorization shall remain in effect until the above described disclosure is complete but shall not extend beyond 180 days from the date of signature. Signing this form is voluntary. I understand that I have the right to revoke this authorization and the right to inspect or get a copy of the material to be disclosed. See reverse side for details on disclosure of information and my rights. I have read both pages of this form and voluntarily authorize and request the disclosure above. I authorize use of a copy (including facsimile) of this form for the disclosure as described above.

Patient Name (Last, First, MI) _____ SSN _____

Birth Date _____ Phone Number (___) _____

Signature, Patient or Legal Representative _____ Date _____

Relationship to Patient (if signed by Legal Representative) _____

LOMA LINDA UNIVERSITY
MEDICAL CENTER – MURRIETA

28062 Baxter Road
Murrieta, California 92563
phone: 951-290-4510
fax: 951-290-4985

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Important Information Regarding My Rights

Voluntary: I understand authorizing the disclosure of the information identified on the reverse side is voluntary. I need not sign this form to ensure healthcare treatment.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. The revocation will take effect upon receipt. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Right to Inspect: I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524 and that I have a right to a copy of this form.

Redisclosure: I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Questions: If I have questions about disclosure of my health information, I can contact the Health Information Management Department at (951) 290-4510.

Fees: Patient Access (AB610) is charged $ 0.25 per page, plus postage. All fees with exception of the SDI releases shall be collected prior to release.