3009

# AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Print in ink ◆ Failure to provide all information may invalidate this authorization.
**Substance Abuse Records and Psychiatric Records require a separate authorization.*

**FROM WHOM** Specify clinic, specialty, or physician below.

- ☐ Loma Linda University Medical Center (LLUMC)
- ☐ Loma Linda University Children's Hospital (LLUCH)
- ☐ Loma Linda University Health Care (LLUHC)
- ☐ Loma Linda University (LLU)

FACILITY USE ONLY

Requested records have been sent

Date Sent:_____

by:_____

**TO WHOM/INSPECT** Please choose one of the following.

☐ Send records to: _____
Individual/Agency Name

_____
Address City State Zip Code

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

**INFORMATION TO BE RELEASED**

Specify where services were rendered (Clinic Name)_____

☐ **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.

☐ **Billing Summary** Dates of Treatment_____

**PURPOSE** Reason records are to be disclosed.

☐ Continued Care ☐ Personal Use (fee applies) ☐ 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 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 disclosure as described above.

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

Birth Date _____ Phone Number: (___)_____

Signature, Patient or Legal Representative _____ Date_____ Time_____

*(Minors 12 years or older must sign as patient along with the guardian)*

Relationship to Patient (if signed by Legal Representative)_____

Interpreter Signature _____ Date_____ Time_____

Interpreter Name (print) _____

Interpreter Telephone ID# _____

Loma Linda University
Loma Linda University Medical Center
Loma Linda University Children's Hospital
Loma Linda University Community Medical Center
Loma Linda University Behavioral Medicine Center
Loma Linda University Health System

**AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

116-3009 (6-14)

PATIENT IDENTIFICATION

# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

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.

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