AUTHORIZATION TO OBTAIN HEALTH INFORMATION
From
Outside Health Care Providers

Patient Name: ________________________ **Medical Record Number:** _______________

Date of Birth: ________________________

I, the undersigned hereby authorize:

____

Name of physician or facility to release health information

____

Physician or Facility Street address

City, State: ____________________________________ **Zip Code:** ______

Telephone: _____________ **Fax Number:** _____________

To be released to:

DR. THOMAS AHLERING (714) 456-6068 FAX # (888) 378-4524
333 CITY BLVD., WEST STUITE 2100 ORANGE, CA 92868

____

UCIMC Unit and/or Clinic requesting Health Information

Information to be RELEASED

☐ Discharge Summary	☐ Laboratory Reports	☐ Emergency Medicine Reports
☐ Billing Statements	☐ Dental Records	☐ History & Physical Exams
☐ Pathology Reports	☐ Operative Reports	☐ Diagnostic Imaging Reports
☐ EKG	☐ Radiology Reports	☐ Consultations
☐ Progress Notes		☐ Outpatient Clinic Records
☐ Vaccinations/immunizations		
☐ Other		

SPECIFY THE DATE OR TIME PERIOD FOR INFORMATION SELECTED ABOVE

Date: ______________________________ Time: __________

SPECIFIC AUTHORIZATIONS

The following information will not be released unless you specially authorize it by marking the relevant box(es) below:

☐ I specially authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment (42 C.F.R. §§ 2.34 and 2.35)

☐ I specially authorize the release of information pertaining to mental health diagnosis or treatment (welfare and Institutions Code §§ 5328, *et seq.*)

☐ I specially authorize the release of HIV/AIDS testing information (Health and Safety Code §120890 (g)).

☐ I specially authorize the release of genetic testing information (Health and Safety Code §124980(j)).

AUTHORIZATION TO OBTAIN HEALTH INFORMATION
From
Outside Health Care Providers

The purpose of this release is (*check one or more*)

- ☐ Continuity of care or discharge planning
- ☐ Billing and payment of bill
- ☐ At the request of the patient/patient representative
- ☐ Other (state reason) ______________________________

Notice

UCIMC 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.

My Rights

- I understand this authorization is voluntary. Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing his 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 of which, 3) to determine an entity's obligation to pay a claim, or 4) to create health information to provide to a third party. Under no circumstances, however, am I required to authorize the release of mental health records.
- 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 Care provider listed above. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I am entitled to receive a copy of this Authorization.

Signature

Date: ________________

(Signature of Patient or Patient's Legal Representative)

Printed Name

Time: ________ AM/PM

(If signed by someone other than the patient, state your legal relationship to the patient/authority)

Witness or Translator