AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) FOR MENTAL HEALTH/CHEMICAL DEPENDENCY

FACILITY USE ONLY
Requested records have been sent:
_____
_____
By:_____
Date:_____

Dates of Treatment:_____

Check the box that applies:

☑ Release my **Loma Linda University Behavioral Medicine Center records** to:

❑ Obtain my records from: (A different facility)

❑ Make records available for review.
Please confirm record review appointment.

❑ Release Billing Summary to:

❑ I authorize release of HIV test results.

THIS IS WHERE YOU WANT YOUR RECORDS TO GO - REQUIRED

Individual /Agency Name ***Please Print*** **Phone Number**

YOU MUST PROVIDE AN ADDRESS

Address **Fax Number**

FOR YOUR REQUEST TO BE PROCESSED

City **State** **Zip Code**

Records released are authorized for the following purpose:

❑ Continued Care ❑ Personal Use ❑ Other _____

I understand authorizing the disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. 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 Medical Record Department. 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. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____
If I fail to specify an expiration date, event or condition, this authorization will expire 90 days from the date of signature. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Medical Record Department.

PATIENT'S NAME **PATIENT'S (DOB)**

Patient Name (Last, First M.I.) **PLEASE PRINT** **Date of Birth**

MUST HAVE LEGAL SIGNATURE **MUST DATE**

Signature of Patient or Legal Representative **Date**

PRINT THE NAME OF THE PERSON SIGNING THIS FORM IF OTHER THAN THE PATIENT

Print Name **Relationship to Patient** **CONTACT PHONE #** **Phone Number**

LOMA LINDA UNIVERSITY BEHAVIORAL MEDICINE CENTER
1710 Barton Road, Redlands, CA 92373
Phone: (909) 651-4853 Fax: (909) 651-4856

AUTHORIZATION FOR RELEASE OF PHI FOR MENTAL HEALTH/ CHEMICAL DEPENDENCY

PATIENT IDENTIFICATION
FACILITY USE ONLY

THIS SAMPLE IS PROVIDED TO ASSIST YOU IN COMPLETING THIS FORM