B1038

AUTHORIZATION FOR RELEASE OF PHI (PROTECTED HEALTH INFORMATION) FOR MENTAL HEALTH/SUBSTANCE USE RECOVERY

FACILITY USE ONLY
Requested records were 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:
- ❑ Release Billing Summary to:
- ❑ Make records available for review and confirm record review appointment.
- ❑ I authorize release of HIV test results.

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

Address **Fax Number**

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 180 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 Name (Last, First M.I.) **Date of Birth**

Signature _____ Date _____ Time _____
(Patient or Legal Representative)

Print Name **Relationship to Patient** **Phone Number**

PHP/IOP/Outpatient Record Requests: A patient 12 years or older must also sign the Release.

Signature _____ Date _____ Time _____

LOMA LINDA UNIVERSITY MEDICAL CENTER

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BEHAVIORAL MEDICINE CENTER

White –facility Pink-Patient

PATIENT IDENTIFICATION