LOMA LINDA UNIVERSITY

MEDICAL CENTER

Behavioral Medicine Center

Enclosed please find an authorization to release

Protected Health Information (PHI)
For Mental Health / Substance Use Recovery

A *sample* has been provided to assist
in completion of this authorization form.

Authorization forms are available by email:
BMCMedicalRecords@llu.edu

Authorizations are available on our website
http://behavioral-medicine-center.lomalindahealth.org

Once the authorization has been completed, you may return it to

Direct Mail
Loma Linda University Medical Center
Behavioral Medicine Center
1710 Barton Road
Redlands, CA 92373

Email:
BMCMedicalRecords@llu.edu

Facsimile
Our fax number is: (909) 651-4856

If you have any questions, you may reach the medical record department at:
(909) 651-4853

Hours
Monday – Thursday 8am to 4pm
Friday 8am to 1pm

B1038

FACILITY USE ONLY
Requested records were sent:
_____
By: _____
Date: _____

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

Dates of Treatment: _____ _____ If unsure of dates please write "ALL"

Check the box that applies:

** ☒ Release my Loma Linda University Medical Center - Behavioral Medicine Center records to: **
☐ Obtain my records from: For Internal Requests
☐ Release Billing Summary to:

☐ Make records available for review and confirm record review appointment.
☐ I authorize release of HIV test results.

** Recipient: This is where you want your records to go

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

Mailing address required for your request to be processed

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 Health Information Management 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 45 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 Health Information Management department.

** Patient Name Please Print ** Patient's Date of Birth

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

Signature ** Signature Required ** Date of Signature Date Required 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
1710 Barton Road, Redlands, CA 92373
Phone (909) 651-4853 Fax (909) 651-4856

LOMA LINDA UNIVERSITY MEDICAL CENTER

AUTHORIZATION FOR RELEASE OF PHI FOR MENTAL HEALTH/ SUBSTANCE USE RECOVERY BEHAVIORAL MEDICINE CENTER

White: Facility Pink: Patient

PATIENT IDENTIFICATION

B1038

FACILITY USE ONLY
Requested records were sent:
_____
By:_____
Date:_____

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

Dates of Treatment: _____

Check the box that applies:

- ❑ Release my Loma Linda University Medical Center - 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 Health Information Management 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 45 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 Health Information Management 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 _____

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AUTHORIZATION FOR RELEASE OF PHI FOR MENTAL HEALTH/ SUBSTANCE USE RECOVERY
BEHAVIORAL MEDICINE CENTER

LOMA LINDA UNIVERSITY MEDICAL CENTER

White –facility Pink-Patient

PATIENT IDENTIFICATION