

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

A Seventh-day Adventist Institution

HEALTH INFORMATION MANAGEMENT | 1710 Barton Road, Redlands, California 92373

Phone (909) 651-4853 · Fax (909) 651-4856



B1038

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

Requested records were sent	FACILITY US	EONLY
Rv		
	Ву:	

Dates of Treatment:	If unsure of dates please write "ALL"
Check the box that applies: Release my Loma Linda University	rsity Medical
Center - Behavioral Medicine	Center records to: ** confirm record review appointment.
Obtain my records from: For I	ternal Requests
☐ Release Billing Summary to:	
Recipient: This is where	you want your records to go
murridual /Agency Name Please Pr	W Phone Number
	your request to be processed
Address	Fax Number
City	State Zip Code
Records released are authorized	
☐ Continued Care ☐ Perso	
I understand authorizing the disclos	ure of the information , entified above is voluntary. I need no
sign this form to ensure healthcar	treatment. I inder tand by I have the right to revoke this
authorization at any time. I under	tand that if I evoke this authorization I must do so in writing
understand that the revocation wi	on to the Heart Information Management department. I not apply into mation that has already been released in
response to this authorization. I	nder tand that he revocation will not apply to my incurrence
company when the law provides a	nder tand that we revocation will not apply to my insurance by inverse to the right to contest a claim under my policy
Unless otherwise revoked, this au	rization will expire on the following date event or condition:
If I fail to specify	n explicit of the following date, event, or condition.
expire 180 days from the date of si	ure. I understand that I may inspect or obtain a copy of the
information to be used of disclos	as provided in 45 CFR 164.524. I understand that any
disclosure of information contest	in 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 Signature Date of Birth
Signature Required	Date Required Time
(Patient or Legal Represer	ative)
Print Name Re	ationship to Patient Phone Number
PHP/IOP/Outpatient Record Requests:	A patient 12 years or older must also sign the Release.
Signature	Date Time
1710 Barton Roa	PATIENT IDENTIFICATION 1, Redlands, CA 92373 153 Fax: (909) 651-4856
THE REAL PROPERTY OF THE PROPE	טנסף וכט (פטב) אווז ככ



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

MEDICAL CENTER White facility Pink-Patient

BMC 1038 Rev. 07/2023

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

FACILITY USI	EONLY
Requested record	
D	
By:	

			Date
Dates of Treatr	nent:		
지나 있다면 사람들이 살아 있다. 그렇게 되어 있다면 하다면 하다 하다 때 그래요?	Loma Linda University Medical		Make records available for review and
	havioral Medicine Center records to:		confirm record review appointment.
Obtain my			authorize release of HIV test results.
☐ Release Bil	ling Summary to:		
Individual /Agen	cy Name Please Print	- 77	Phone Number
Address			Fax Number
City	State		Zip Code
	ed are authorized for the following		
☐ Continued C		I Othe	
I understand aut	thorizing the disclosure of the information	ion id	entified above is voluntary. I need not
sign this form	to ensure healthcare treatment. I und	lerstar	d that I have the right to revoke this
authorization at	any time. I understand that if I revo	ke this	s authorization I must do so in writing
and present m	y written revocation to the Health	Infor	mation Management department. I
understand that	the revocation will not apply to inf	ormat	ion that has already been released in
response to this	authorization. I understand that the	revo	cation will not apply to my insurance
company when	the law provides my insurer with the	e righ	t to contest a claim under my policy.
Unless otherwis	e revoked, this authorization will expir	e on th	ne following date, event, or condition: _
II	I fail to specify an expiration date,	even	t or condition, this authorization will
expire 180 days	from the date of signature. I understa	nd tha	t I may inspect or obtain a copy of the
disologura of in	be used or disclosed, as provided in	45 (CFR 164.524. I understand that any
information mo	what he protected he federal as f	l for	an unauthorized re-disclosure and the
disclosure of my	health information I are annual the I	lential	ity rules. If I have questions about
disclosure of my	neath information, I can contact the I	ieaith	Information Management department.
Patient Name (Las	st, First M.I.)	-	Date of Birth
Signature	D	ate	Time
(Pa	tient or Legal Representative))	
Print Name	Relationship to Patient		Phone Number
PHP/IOP/Outpati	ent Record Requests: A patient 12 years of	older	must also sign the Release.
Signature	D	ate	Time
, non	Loma Linda University Medical Center		PATIENT IDENTIFICATION



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