

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 9 am to 3 pm Friday 8am to 12 pm

A Seventh-day Adventist Institution HEALTH INFORMATION MANAGEMENT 1710 Barton Road, Redlands, California 92373 Phone (909) 651-4853 · Fax (909) 651-4856



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

FACILITY USE O	NLY
Requested records v	vere sent:
Ву:	
Date:	

Dates of Treatment:	If unsure of dates please write "ALL"
Check the box that applies:	
Release my Loma Linda Univer	sity Medical Make records available for review and
Center - Behavioral Medicine C	
 Obtain my records from: For In Release Billing Summary to: 	ternal Requests
**n	
**Recipient: This is where y	ou want your records to go
Individual /Agency Name Please Prin Mailing address required for	Phone Number
Address	▲ Fax Number
444	
City	State Zip Code
Records released are authorized	
☐ Continued Care ☐ Person	
I understand authorizing the disclosi	are of the information dentified above is voluntary. I need not
sign this form to ensure healthcare	treatment. I indea tand by I have the right to revoke this
authorization at any time. I undersi	and that if I wok this authorization I must do so in writing
and present my written revocatio	n to the Hear Information Management department. I
understand that the revocation will	not apply in mation that has already been released in
response to this authorization. I un	nder tand that we revocation will not apply to my insurance y in the right to contest a claim under my policy.
Unless otherwise revoked this suffer	y in the right to contest a claim under my policy.
If I fail to engels	rization will expire on the following date, event, or condition:
evnire 180 days from the data of s	understand that I may inspect or obtain a copy of the
information to be used a disclose	as provided in 45 CFR 164.524. I understand that any
disclosure of information	in it the potential for an unauthorized re-disclosure and the
information may not be protecte	by federal confidentiality rules. If I have questions about
disclosure of my health informan	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 Representa	ntive)
Print Name Rela	itionship to Patient Phone Number
PHP/IOP/Outpatient Record Requests:	A patient 12 years or older must also sign the Release.
Signature	Date Time
	rsity Medical Center PATIENT IDENTIFICATION
	Redlands, CA 923*3 53 Fax (909) 651-4856
	R RELEASE OF PHI FOR
MENTAL HEALTH/SUR	STANCE USE RECOVERY
LOMA LINDA DELLA MODAL NA	EDICINE CENTED

UNIVERSITY

BEHAVIORAL MEDICINE CENTER

MEDICAL CENTER White facility Pink Patient BMC 1038 Rev. 07/2023 2,000 7 1 2023



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

Requested records were sent:	Requested records were sent:	Requested records were sent By:	FACILIT	Y USE ONLY
			Requested	records were sent:
**		Dyn	recquestea	records were sent.

		The state of the s	
Dates of Treatment:		3	
Check the box that applies:	TT 1 2 3 3 7 3 3		920
Release my Loma Linda		☐ Make records available for review	
	dicine Center records to:	confirm record review appointmen	
Obtain my records from		☐ I authorize release of HIV test resu	ılts.
☐ Release Billing Summar	y to.		
Individual /Agency Name Pla	ease Print	Phone Number	
Address		Fax Number	
City	State	Zip Code	
Records released are auth	orized for the following	purpose:	
		Other	
I understand authorizing the	disclosure of the informat	tion identified above is voluntary. I nee	d not
sign this form to ensure he	althcare treatment. I und	derstand that I have the right to revoke	this
authorization at any time. I	understand that if I revol	ke this authorization I must do so in wi	riting
and present my written re	evocation to the Health	Information Management department	t. I
understand that the revocat	ion will not apply to infe	formation that has already been release	ed in
response to this authorization	on. I understand that the	e revocation will not apply to my insur	rance
		e right to contest a claim under my po	
		e on the following date, event, or conditi	
		event or condition, this authorization	
expire 180 days from the dat	e of signature. I understa	nd that I may inspect or obtain a copy of	of the
information to be used or	disclosed, as provided in	45 CFR 164.524. I understand that	any
disclosure of information ca	irries with it the potentia	l for an unauthorized re-disclosure and	i the
information may not be pro	otected by federal confid	lentiality rules. If I have questions a	ıbout
disclosure of my health infor	mation, I can contact the H	Health Information Management departm	ient.
Patient Name (Last, First M.I.)		Date of Birth	
Signature	D	Date Time	
(Patient or Legal R	(epresentative)	Pate Time	
Print Name	Relationship to Patient	Phone Number	
PHP/IOP/Outpatient Record Re	quests: A patient 12 years or	r older must also sign the Release.	
Signature	D	PATIENT IDENTIFICATION	
. Ioma Liv	nda University Medical Canton	PATIENT IDENTIFICATION	_



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White-facility Pink-Patient

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