LOMA LINDA UNIVERSITY

MEDICAL CENTER

Behavioral Medicine Center

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

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 _____

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LOMA LINDA UNIVERSITY MEDICAL CENTER

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

White Society Pink Patient

BMC 1038 Rev. 07/2023
2,000 7 1 2023

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

PATIENT IDENTIFICATION