LOMA LINDA UNIVERSITY
BEHAVIORAL MEDICINE CENTER

Enclosed please find an authorization to release

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

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

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

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

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

Or, you may return this authorization by facsimile
Our fax number is: (909) 651-4856

Or, you may return it by email to:
BMCMedicalRecords@llu.edu

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

A Seventh-day Adventist Institution
HEALTH INFORMATION MANAGEMENT | 1710 Barton Road, Redlands, California 92373
(909) 651-4853 · fax (909) 651-4856
http://behavioral-medicine-center.lomalindahealth.org

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:**
- ☐ Make records available for review and confirm record review appointment.
- ☐ Obtain my records from:
- ☐ Release Billing Summary to:
- ☐ I authorize release of HIV test results.

THIS IS WHERE YOU WANT YOUR RECORDS TO GO

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

ADDRESS REQUIRED FOR PROCESSING

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'S NAMED ____________ **PATIENT'S DOB**
Patient Name (Last, First M.I.) **Date of Birth**

Signature *****SIGNATURE REQUIRED** ____________ Date **REQUIRED** Time ____________
(Patient or Legal Representative)

____________ ____________ **CONTACT PHONE NUMBER**
Print Name **Relationship to Patient** **Phone Number**

PHP/IOP/Outpatient Record Requests: A patient 12 years or older must also sign the Release.
If the patient is a minor please obtain TWO SIGNATURES Parent and Minor

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AUTHORIZATION FOR RELEASE OF PHI FOR MENTAL HEALTH/ SUBSTANCE USE RECOVERY

White – facility Pink-Patient BMC 1038 Rev. 11/2019

PATIENT IDENTIFICATION

SAMPLE

B1038

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

Signature ______________________________ Date ____________ Time ____________
(Patient or Legal Representative)

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

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AUTHORIZATION FOR RELEASE OF PHI FOR MENTAL HEALTH/ SUBSTANCE USE RECOVERY

PATIENT IDENTIFICATION