UC Davis Health
Ambulatory Administration

Instructions on Use and Completion of the Standard UCD Release of Information form for Verbal Communication

References:
Policy 1415 Patient Care Decision-Making Process
Policy 2414 Disclosing Protected Health Information by a Valid HIPAA Authorization
Policy 2422 Disclosing Protected Health Information to Family and Friends

Please use the form attached for verbal communication with caregivers who may call on behalf of a UC Davis patient to coordinate care, make, modify or cancel appointments, etc.

The standard UCD form provides two options where the patient may direct UCD how to use the form.

1) Verbal Communication
2) Release of Copies of Medical Records

Question: When do I advise the patient to mark the "Verbal Communication" check box?

- When patient authorizes UC Davis Staff/care team to communicate verbally with their caregiver, family members, or other designated representatives. This may include the coordination of care such as making appointments/modifying appointments, etc.
- The authorization should be completed in its entirety except for the 'Release Delivery Options' which will be "Verbal Communication" as designated above.

Question: When do I advise the patient to mark the "Release of Copies of Medical Records" check box?

- When the patient/patient representative is requesting/authorizing 'copies' of their medical records to be released.
- The authorization should be completed in its entirety.

Question: Is this form appropriate when the patient would like a caregiver, family member or designated representative to make healthcare decision on their behalf?

- No: Patient must submit an Advance Care Directive or Power of Attorney for Healthcare or like documents designating someone else to make healthcare decisions.
- For more information, please contact the HIM Department or visit the following UCDH website: Healthcare Decisions and Living Wills Resources | Health Education | UC Davis Health

PATIENT NAME: _____
DATE OF BIRTH: _____
UC Davis Health MEDICAL RECORD #: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone #: _____
Email (recommended): _____

UC DAVIS HEALTH

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

☐ Verbal Communication
☐ Release of 'Copies' of Medical Records

I hereby authorize:	To release health information to:
Name of person / facility to release health information	Name of person / facility to receive health information
Street Address, City, State, Zip Code	Street Address, City, State, Zip Code

Type(s) of Health Information to be Released for the following date range: _____ to _____

☐ Medical Records ☐ Radiology Images ☐ Billing Records ☐ Other: _____
☐ Records limited to the following provider(s) or department(s): _____
I further authorize the release of information for treatment provided after the date of signature on this authorization, as long as such treatment occurs while this authorization has not expired. _____ (initials)

The information below is protected by law and will not be released unless you specifically authorize:	
☐ Mental Health (other than psychotherapy notes) Records For psychotherapy notes, complete the psychotherapy authorization form.	☐ HIV Test Results Records
☐ Drug/Alcohol Abuse Treatment Records	☐ Genetic Testing Information Records

Release Delivery Options (select one):

US Mail	Electronically	Fax	On-Site Inspection
☐ Paper ☐ CD	☐ Secured Email ☐ MyUCDavisHealth	☐ Fax (continuation of care only) *Fax #* _____ - _____ - _____	☐ Paper Chart

The purpose of this release is for: ☐ Patient/Patient Representative ☐ Other: _____

Notice: Fees may apply for copies of your records. Unless required by law, California law prohibits the recipient from further disclosing your health information unless the recipient obtains another authorization from you. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

Your Rights: This authorization to release health information in voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this form. You may revoke this authorization at any time. The revocation must be in writing, signed by you or your patient representative, and mail to: UC Davis Health, Health Information Management, 2315 Stockton Blvd., Sacramento, CA 95817. The revocation will take effect when UC Davis Health receives it, except to the extent UC Davis Health or others have already relied on it. A copy of this authorization is valid as the original. You are entitled to receive a copy of this authorization.

Expiration of Authorization: Unless otherwise revoked, this authorization expires _____ (insert date). If no date is indicated, the authorization will expire 12 months after the date of my signing this form.

Date	Print Name	Patient / Patient Rep Signature	Relationship to Patient

_____
Interpreter Signature, if applicable