UC DAVIS HEALTH

HIM Release of Information

Release of Information Services are now Virtual

UC Davis Health Health Information Management has virtualized all services. Front Desk services are no longer available
.

For additional information regarding the move and Release of Information forms, please visit our website at

https://health.ucdavis.edu/him/ or email roi@health.ucdavis.edu.

To All Patients:

HIM Release of Information Department is **virtual**.

For general and urgent request for your records, we got you covered by submitting your completed authorization to:

- Email: roi@health.ucdavis.edu
- Fax: 916-734-2126
- Post Office Mail:

UC Davis Health
Attn: Health Information Management
2315 Stockton Blvd.
Sacramento, CA 95817

Patient's may also electronically request and receive copies of their medical records via **MyUCDavisHealth (MyChart)**.

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

UCDAVIS 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):

Electronically	US Mail	Fax	On-Site Inspection
☐ MyUCDavisHealth *(no fee)* ☐ Secured Email: *(email address required)* _____@_____	☐ Paper ☐ CD	☐ 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 is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon 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 mailed to: UC Davis Health, Health Information Management, 2315 Stockton Blvd., Sacramento, CA 95817. The revocation will take effect when UC Davis Health receives and processes the request. 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