

**We will virtualize
all services
Effective
April 1st, 2022**

UC Davis Health Health Information Management is moving to a NEW LOCATION in Mather and will virtualize all Release of Information services. Front Desk services will no longer be available. We apologize for any inconvenience.

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



<https://health.ucdavis.edu/him/>
or email hs-roi@ucdavis.edu.

To All Patients: Effective April 1st, 2022 the HIM Release of Information Department will **virtualize** all Release of Information services.

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

- Email: hs-roi@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**.



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

UC DAVIS HEALTH
 SACRAMENTO, CALIFORNIA

**AUTHORIZATION FOR RELEASE
 OF HEALTH INFORMATION**

Verbal Communication Only (For Internal Use)

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:

- | | |
|---|--|
| <input type="checkbox"/> Mental Health (other than psychotherapy notes)
<small>For psychotherapy notes, complete the psychotherapy authorization form.</small> | <input type="checkbox"/> HIV Test Results |
| <input type="checkbox"/> Drug/Alcohol Abuse Treatment Records | <input type="checkbox"/> Genetic Testing Information |

Release Delivery Options (select one):

US Mail	Electronically	Fax	On-Site Inspection
<input type="checkbox"/> Paper <input type="checkbox"/> CD	<input type="checkbox"/> Secured Email <input type="checkbox"/> MyUCDavisHealth	<input type="checkbox"/> Fax (continuation of care only) Fax # _____ - _____ - _____	<input type="checkbox"/> 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 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

