Effective as of January 1, 2006
Please send all completed forms to:

Mailing Address:

UC Davis Health
Health Information Management
Medical/Legal Release of Information Unit
2315 Stockton Blvd.
Building #12
Sacramento, CA 95817

Or via

Electronic Communications:

hs-roi@ucdavis.edu

Or via

Fax:

(916) 734-2126

For additional information please call:
(916) 734-5205

PRINT RESET

PATIENT NAME: _____
DATE OF BIRTH: _____
UCD MEDICAL RECORD #: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone #: _____
Email (optional): _____

UNIVERSITY OF CALIFORNIA, DAVIS
MEDICAL CENTER
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 _____

☐ Any and All Medical Records ☐ Radiology Images ☐ Billing Records
☐ Records limited to the following provider(s) or department(s): _____
☐ Other: _____

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) For psychotherapy notes, complete the psychotherapy authorization form	☐ HIV Test Results
☐ Drug/Alcohol Abuse Treatment Records	☐ Genetic Testing Information

Type of Release *(select one)*:	Delivery Method *(select one)*:
☐ Paper ☐ CD ☐ On-Site Inspection	☐ Mail ☐ Pick-Up ☐ Fax (continuation of care only)

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 delivered to: UCDHS Health Information Management Department, 2315 Stockton Blvd., Building 12, Sacramento, CA 95817. The revocation will take effect when UCDHS receives it, except to the extent UCDHS 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

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