(Our mission is to treats everyone with dignity, respect and cultural sensitivity to help create an environment which we all can prosper)

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Note to Client: A FEE MAY APPLY TO THIS REQUEST FOR RECORDS.

CLIENT (PATIENT) INFORMATION

Name _____ Telephone: (____) _____
LAST FIRST MI

_____
STREET ADDRESS CITY STATE ZIP CODE

SSN: _____ - _____ - _____ Date of Birth _____ Patient Record Number:_____

The undersigned hereby authorizes the disclosure of the Protected Health Information (PHI) from UCHC Disclose PHI to:

_____
Name of Facility Producing Records Person/Agency

_____
Street Address/Mailing Address Street Address

_____
City State Zip

(____)_____ (____)_____ (____)_____(_____)_____
Phone # Fax # Phone # Fax #

DISCLOSED: (Please check all applicable categories)

□ Complete Copy of Medical Records
□ Alcohol Treatment/Evaluation
□ Allergy Records
□ AIDS/AIDS-Related Illness
□ Developmental Disabilities
□ X-Ray Reports/Films
□ HIV Test Results
□ Mental Health Records
□ Immunization Records
□ Other (please specify):
□ Dental Records
□ Lab Reports
□ Drug Treatment/Evaluation
□ Physical Exams

_____
_____
(e.g., the request of the individual, continuity of care, attorney access, court case, insurance, disability, etc.)

Expires as specified: _____
(Authorization includes future records generated until expiration)

I hereby authorize the release of the PHI of the above named individual in accordance with the specifications listed above. I understand that I have a right to receive a copy of the disclosed material.

A photocopy/fax of this consent shall be valid as the original.

Signature: _____ Date: _____

Printed Name: _____

Relationship to above named individual: _____

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[ ] 1501 E. Holt Ave. #A * Pomona, CA 91767 * Telephone (909) 623-3600 * Fax (909) 623-3383
[ ] 570 S. Mt. Vernon Ave. #G * San Bernardino, CA 92410 * Telephone (909) 884-6700 * Fax (909) 884-6705