3009

Please fax Request to:(909)558-0735

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Print in ink ◆ Failure to provide all information may invalidate this authorization.
**Substance Abuse Records and Psychiatric Records require a separate authorization.*

FROM WHOM Specify clinic, specialty, or physician below.

- ☐ Loma Linda University Medical Center (LLUMC)
- ☐ Loma Linda University Health Care (LLUHC)
- ☐ Loma Linda University (LLU)

FACILITY USE ONLY

Requested records have been sent

Date Sent:_____

by:_____

TO WHOM/INSPECT Please choose one of the following.

- ☐ Send records to: _____
  Individual/Agency Name
  _____
  Address City State Zip Code
- ☐ Make records available for review. Confirm appointment prior to review.

INFORMATION TO BE RELEASED

Specify where services were rendered (Clinic Name)_____

- ☐ **Inpatient** Dates of Treatment_____
  - ☐ Discharge Summary ☐ Standard Clinical Pertinent Documents
  - ☐ Other, Specify_____
- ☐ **Outpatient** Dates of Treatment_____
  - ☐ Clinical Notes ☐ Test Results, type of test_____
  - ☐ Other, Specify_____
- ☐ I specifically authorize release of HIV test results.
- ☐ **Billing Summary** Dates of Treatment_____

PURPOSE Reason records are to be disclosed.

☐ Continued Care ☐ Personal Use (fee applies) ☐ Other, Specify_____

Unless otherwise revoked, this authorization will expire on the following date, event or condition_____. This authorization shall remain in effect until the above described disclosure is complete but shall not extend beyond 180 days from the date of signature. Signing this form is voluntary. I understand I have the right to revoke this authorization and the right to inspect or get a copy of the material to be disclosed. **See reverse side for details on disclosure of information and my rights.** I have read both pages of this form and voluntarily authorize and request the disclosure above. I authorize use of a copy (including facsimile) of this form for disclosure as described above.

Patient Name (Last, First MI)_____ SSN _____

Birth Date _____ Phone Number (____) _____

Signature, Patient or Legal Representative _____ Date _____

Relationship to Patient (if signed by Legal Representative) _____

PATIENT IDENTIFICATION

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