Riverside University HEALTH SYSTEM

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

RUHS Health Information Management, Release of Information
7898 Mission Grove Parkway South, Suite 200, Riverside, CA 92508
Phone: 951-486-5040 • Fax: 951-486-5075 • Email: RUHS-ROI@ruhealth.org

Patient Information

Patient Name: _____ Date of Birth: _____
Prior Name(s) Used: _____ Phone #:_____
Medical Record Number: _____ Last 4 digits of Social Security: _____
Address: _____

Release to:

I authorize Riverside University Health System to release health information to:

*Person/Facility:*_____
*Address:*_____
_____
*Phone:*_____ *Fax:*_____

Receive from:

I authorize Riverside University Health System to receive health information from:

*Person/Facility:*_____
Address: _____
_____
*Phone:*_____ *Fax:*_____

Facility location

Specify which healthcare facility records you are requesting to release:

- ☐ Riverside University Health System – Medical Center: 26520 Cactus Ave, Moreno Valley, CA 92555
- ☐ Riverside University Health System – Arlington Mental Health: 9990 County Farm Rd, Riverside, CA 92503
- ☐ RUHS – Medical Surgical Center: 26600 Cactus Ave, Moreno Valley, CA 92555
- ☐ RUHS Community Health Center (Specify Clinic): _____

Purpose

Purpose of this release *(Check all that apply)**:***

☐ Personal Use ☐ Continuity of Care ☐ Billing ☐ Disability ☐ Insurance ☐ Legal
☐ Other (state reason): _____

Information to Release

Date(s) of Service from: _____ to _____

- ☐ Billing Information
- ☐ Consultation Reports
- ☐ Discharge Summary
- ☐ Emergency Records
- ☐ History and Physical
- ☐ Laboratory Reports
- ☐ Medication List
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ Progress Notes
- ☐ Radiology Reports
- ☐ Visit History
- ☐ Entire Record
- ☐ Other: _____

_____

Specific Authorizations

*The following information will not be released without the **initials** of the patient*

_____ Alcohol/Drug treatment information
_____ Genetic testing information
_____ HIV/AIDS records/treatment information
_____ Mental Health treatment information
(Physician approval may be required prior to release)

Delivery

Please send records via:

☐ MyChart ☐ Mail records ☐ Pick-up: (Paper) or (Media: CD) ☐ Fax to: _____
☐ Other: _____

Fees may be associated with this request. Some records are unavailable to receive via MyChart.

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Notice of Rights and Other information	**Notice:** It is my understanding that I have the legal right, with certain limitations, to either view or obtain copies of my protected health information, or that of my unemancipated minor child whose treatment I authorized. This right is also granted to the guardian of a minor child, conservator of the person, psychiatric or nonpsychiatric. Riverside University Health System and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your protected health information (PHI) confidential. If you have authorized the disclosure of your PHI to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws. **Voluntary**: I understand authorizing the disclosure of the information identified is voluntary. Treatment, payment enrollment, or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) to obtain information in connection with eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a claim, or 4) to create PHI to provide to a third party. **Right to Revoke**: I understand that I have the right to revoke this authorization at any time by mailing or personally delivering a signed, written revocation to Riverside University Health System - Health Information Management Department. Such revocation will take effect upon receipt, except to the extent that the recipient has taken action on this Authorization. **Right to Inspect**: I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 CFR 164.524 and that I have a right to a copy of this form. **Redisclosure**: I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. **Questions**: If I have questions about disclosure of my health information, I can contact the Health Information Management Department at **951-486-5040.**
Expiration	Unless otherwise revoked in writing, this authorization will expire on the following date, _____. If no date is indicated, this authorization will expire six months after the date signed.
Signature	I have read both pages of this form and voluntarily authorize and request the disclosure above. Signature: _____ Date: _____ Time: _____ (Patient or Legal Representative) If signed by someone other than the patient, indicate relationship to the patient: _____