

**AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

**RUHS - Public Health Custodian of Records**

10769 Hole Avenue, Suite 220, Riverside, CA 92505

Tel: 951.358.6082 Fax: 951.358.5294

**PATIENT INFORMATION:**

|                     |                                   |                    |
|---------------------|-----------------------------------|--------------------|
| Patient Name:       |                                   | Date of Birth:     |
| Prior Name(s) Used: |                                   | Tel: (     )     - |
| Address:            |                                   |                    |
| Medical Record #:   | Last 4 digits of Social Security: |                    |

**I HEREBY AUTHORIZE RUHS – PUBLIC HEALTH TO: (Check all that apply)**

|                                                            |                                                             |
|------------------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> Release my health information to: | <input type="checkbox"/> Obtain my health information from: |
| Name of person / entity:                                   | Tel: (     )     -                                          |
| Address:                                                   |                                                             |

**DELIVERY METHOD: Please send records via (choose one of the following:)**

|                                    |                                  |                                               |                                 |
|------------------------------------|----------------------------------|-----------------------------------------------|---------------------------------|
| <input type="checkbox"/> USPS Mail | <input type="checkbox"/> Pick-up | <input type="checkbox"/> Fax #: (     )     - | <input type="checkbox"/> Other: |
|------------------------------------|----------------------------------|-----------------------------------------------|---------------------------------|

**SPECIFY THE PROGRAM FROM WHICH HEALTH RECORDS ARE BEING REQUESTED:**

|                                                               |                                                                             |
|---------------------------------------------------------------|-----------------------------------------------------------------------------|
| <input type="checkbox"/> Communicable Diseases                | <input type="checkbox"/> Early Intervention / HIV Care Services and Testing |
| <input type="checkbox"/> Maternal Child and Adolescent Health | <input type="checkbox"/> Medical Therapy Program                            |
| <input type="checkbox"/> Public Health Nursing                | <input type="checkbox"/> Tuberculosis Care Services                         |
| <input type="checkbox"/> Other:                               |                                                                             |

**INFORMATION TO BE RELEASED: (Check all that apply)**

| Date(s) of Service:                           | Date from:                                    | Date to:                                    | Date from:                                 | Date to: | Date from: | Date to: |
|-----------------------------------------------|-----------------------------------------------|---------------------------------------------|--------------------------------------------|----------|------------|----------|
|                                               | /                                             |                                             | /                                          |          | /          |          |
| <input type="checkbox"/> Billing Information  | <input type="checkbox"/> EKG                  | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Radiology Reports |          |            |          |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Entire Record        | <input type="checkbox"/> Medication List    | <input type="checkbox"/> Visit History     |          |            |          |
| <input type="checkbox"/> Discharge Summary    | <input type="checkbox"/> History and Physical | <input type="checkbox"/> Progress Notes     | <input type="checkbox"/> Other:            |          |            |          |

**SPECIFIC AUTHORIZATIONS: The following must be initialed by the patient in order to be released:**

|           |                                                                                                  |
|-----------|--------------------------------------------------------------------------------------------------|
| (Initial) | Alcohol / Drug Treatment Information                                                             |
| (Initial) | HIV / AIDS Records / Treatment Information                                                       |
| (Initial) | Mental Health Treatment Information <b>(Physician approval may be required prior to release)</b> |

**PURPOSE OF THIS RELEASE: (Check all that apply)**

|                                       |                                                |                                     |                                    |                                |
|---------------------------------------|------------------------------------------------|-------------------------------------|------------------------------------|--------------------------------|
| <input type="checkbox"/> Billing      | <input type="checkbox"/> Continuity of Care    | <input type="checkbox"/> Disability | <input type="checkbox"/> Insurance | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Personal Use | <input type="checkbox"/> Other (state reason): |                                     |                                    |                                |

It is my understanding that I have the legal right, with certain limitation, to either view or obtain copies of my 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.

**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.

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) | (Relationship to patient, if not patient) | (Date) |
|             |                                           |        |



### Important Information Regarding My Rights

---

**Notice:** RUHS - Public Health and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. 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.

**Voluntary:** I understand authorizing the disclosure of the information identified on the reverse side is voluntary. I need not sign this form to ensure healthcare treatment. 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 RUHS - Public Health Custodian of Records. 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 RUHS - Public Health custodian of records at **951-358-6082**