



B1038

**AUTHORIZATION FOR RELEASE OF
PROTECTED HEALTH INFORMATION (PHI)
FOR MENTAL HEALTH/CHEMICAL DEPENDENCY**

| | |
|----------------------------------|---------------|
| FACILITY USE ONLY | |
| Requested records have been sent | Records _____ |
| By: | _____ |
| Date: | _____ |

Dates of Treatment _____

Check the box that applies:

- Release my Loma Linda University Behavioral Medicine Center records to:
 - Make records available for review. Please confirm record review appointment.
- Obtain my records from:
 - Release Billing Summary to:

Individual /Agency Name *Please Print* _____ Phone Number _____

Address _____ Fax Number _____

City _____ State _____ Zip Code _____

Records released are authorized for the following purpose:

- Continued Care Personal Use Other _____

I understand authorizing the disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____

If I fail to specify an expiration date, event or condition, this authorization will expire 90 days from the date of signature. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Medical Record Department.

- I specifically authorize release of HIV test results.

Patient Name (Last, First M.I.) _____ DOB: _____

SS#: (Optional) _____ Phone #: _____

Signature of Patient or Legal Representative _____ Date _____ Relationship to Patient _____

LOMA LINDA UNIVERSITY BEHAVIORAL MEDICINE CENTER
1710 Barton Road, Redlands, CA 92373

PATIENT IDENTIFICATION



LOMA LINDA
UNIVERSITY
BEHAVIORAL
MEDICINE CENTER

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