



3016

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION FROM A FACILITY OUTSIDE THE LLUAHSC OHCA TO A LLUAHSC ENTITY

Print in ink ♦ Failure to provide all information may invalidate this authorization.

From Whom:

Individual/Agency Name _____

Address _____ City _____ State _____ Zip Code _____

To Whom:

- | | | |
|---|--|--|
| <input type="checkbox"/> LLUMC
P.O. Box 2000
Loma Linda, CA 92354 | <input type="checkbox"/> LLUHC
11370 Anderson Street
Suite 2300
Loma Linda , CA 92354 | <input type="checkbox"/> LLU (See reverse for address)
<input type="checkbox"/> Department of Psychology
<input type="checkbox"/> Center for Health Promotion
<input type="checkbox"/> Marriage & Family Clinic
<input type="checkbox"/> School of Dentistry
<input type="checkbox"/> SACHS |
|---|--|--|

Information to be Released: Date(s) of treatment: _____

- | | | |
|--|---|---|
| <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Standard clinical pertinent document | <input type="checkbox"/> Clinical notes |
| <input type="checkbox"/> Billing records | <input type="checkbox"/> Other, specify: _____ | |
| <input type="checkbox"/> I specifically authorize release of HIV test results. | | |
| <input type="checkbox"/> I specifically authorize release of alcohol/drug treatment information. | | |

Purpose/Reason Records Are to be Disclosed:

- | | | |
|---|---------------------------------------|--|
| <input type="checkbox"/> Continued care | <input type="checkbox"/> Personal use | <input type="checkbox"/> 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: _____ Telephone Number: (____) _____

Signature, Patient or Legal Representative: _____ Date: _____ Time: _____

Relationship to Patient (if signed by Legal Representative): _____



LOMA LINDA UNIVERSITY
LOMA LINDA UNIVERSITY MEDICAL CENTER
LOMA LINDA UNIVERSITY CHILDREN'S HOSPITAL
LOMA LINDA UNIVERSITY COMMUNITY MEDICAL CENTER
LOMA LINDA UNIVERSITY BEHAVIORAL MEDICINE CENTER
LOMA LINDA UNIVERSITY HEALTH CARE

PATIENT IDENTIFICATION

NAME: _____
 Birth Date: _____
 MEDICAL RECORD #: _____

