Riverside University HEALTH SYSTEM Public Health

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

RUHS - Public Health Custodian of Records

4210 Riverwalk Pkwy, Suite 300, 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)	
☐ Release my health information to:	☐ Obtain my health information from:
Name of person / entity:	Tel: ( ) -
Address:	

DELIVERY METHOD: Please send records via (choose one of the following:)				
☐ USPS Mail	☐ Pick-up	☐ Electronic (CD, MyChart)	☐ Fax #: ( ) -	☐ Other:

SPECIFY THE PROGRAM FROM WHICH HEALTH RECORDS ARE BEING REQUESTED:	
☐ Communicable Diseases	☐ Early Intervention / HIV Care Services and Testing
☐ Maternal Child and Adolescent Health	☐ Medical Therapy Program
☐ Public Health Nursing	☐ Tuberculosis Care Services
☐ Other:	☐ Pre-Exposure Prophylaxis (PrEP)

INFORMATION TO BE RELEASED: (Check all that apply)			
Date(s) of Service:	Date from: / Date to:		
☐ Billing Information	☐ EKG	☐ Laboratory Reports	☐ Radiology Reports
☐ Consultation Reports	☐ Entire Record	☐ Medication List	☐ Visit History
☐ Discharge Summary	☐ History and Physical	☐ Progress Notes	☐ 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 **(Physician approval may be required prior to release)**

PURPOSE OF THIS RELEASE: (Check all that apply)				
☐ Billing	☐ Continuity of Care	☐ Disability	☐ Insurance	☐ Legal
☐ Personal Use	☐ 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)*

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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**