

**AUTHORIZATION TO OBTAIN HEALTH INFORMATION**  
**From**  
**Outside Health Care Providers**

**Patient Name:** \_\_\_\_\_ **Medical Record Number:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**I, the undersigned hereby authorize:**

\_\_\_\_\_  
**Name of physician or facility to release health information**

\_\_\_\_\_  
**Physician or Facility Street address**

**City, State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_ **Fax Number:** \_\_\_\_\_

**To be released to:**

DR. THOMAS AHLERING ( 714 ) 456-6068 FAX # ( 888 ) 378-4524  
 3800 W. CHAPMAN AVE, SUITE: 7200 ORANGE, CA 92868

\_\_\_\_\_  
 UCIMC Unit and/or Clinic requesting Health Information

**Information to be RELEASED**

<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Emergency Medicine Reports
<input type="checkbox"/> Billing Statements	<input type="checkbox"/> Dental Records	<input type="checkbox"/> History & Physical Exams
<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Diagnostic Imaging Reports
<input type="checkbox"/> EKG	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Consultations
<input type="checkbox"/> Progress Notes		<input type="checkbox"/> Outpatient Clinic Records
<input type="checkbox"/> Vaccinations/immunizations		
<input type="checkbox"/> Other		

**SPECIFY THE DATE OR TIME PERIOD FOR INFORMATION SELECTED ABOVE**

Date: \_\_\_\_\_ Time: \_\_\_\_\_

**SPECIFIC AUTHORIZATIONS**

The following information will not be released unless you specially authorize it by marking the relevant box(es) below:

- I specially authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment (42 C.F.R. §§ 2.34 and 2.35)
- I specially authorize the release of information pertaining to mental health diagnosis or treatment (welfare and Institutions Code §§ 5328, *et seq.*)
- I specially authorize the release of HIV/AIDS testing information (Health and Safety Code §120890 (g)).
- I specially authorize the release of genetic testing information (Health and Safety Code §124980(j)).

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**The purpose of this release is (check one or more)**

- Continuity of care or discharge planning
- Billing and payment of bill
- At the request of the patient/patient representative
- Other (state reason) \_\_\_\_\_

**Notice**

UCIMC 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.

**My Rights**

- I understand this authorization is voluntary. Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing his 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 of which, 3) to determine an entity's obligation to pay a claim, or 4) to create health information to provide to a third party. Under no circumstances, however, am I required to authorize the release of mental health records.
- 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 Health Care provider listed above. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I am entitled to receive a copy of this Authorization.

**Signature**

(Signature of Patient or Patient's Legal Representative)

Date: \_\_\_\_\_

Printed Name

(If signed by someone other than the patient, state your legal relationship to the patient/authority)

Time: \_\_\_\_\_ AM/PM

Witness or Translator