RIVERSIDE UNIVERSITY HEALTH SYSTEM
AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____
Prior Name(s) Used: _____ Phone #: _____
Medical Record Number: _____ Last 4 digits of Social Security: _____
Address: _____

I hereby authorize Riverside University Health System to: ☐ release my protected health information to:
☐ obtain my protected health information from:
Name of person/facility: _____ Phone #: _____
Address: _____

DELIVERY METHOD: Please send records via: ☐ MyChart ☐ Mail ☐ Pick-up: (Paper) or (Media: CD)
☐ Other: _____

SPECIFY HEALTH CARE FACILITY FROM WHICH PHI IS REQUESTED:

☐ Riverside University Health System – Medical Center: 26520 Cactus Ave, Moreno Valley, CA 92555
☐ Riverside University Health System – Arlington Mental Health: 9990 County Farm Rd, Riverside, CA 92503
☐ Community Health Center (Specify Clinic): _____

INFORMATION TO BE RELEASED: (Check all that apply)

Date(s) of Service from: _____ to _____

☐ Billing Information ☐ Emergency Records ☐ Medication List ☐ Progress Notes
☐ Consultation Reports ☐ History and Physical ☐ Operative Reports ☐ Radiology Reports
☐ Discharge Summary ☐ Laboratory Reports ☐ Pathology Reports ☐ Visit History
☐ Entire Record ☐ Other: _____

---*Specific Authorizations – the following information will not be released without the initials of the patient*

_____ Mental Health Treatment Information (Physician approval may be required prior to release)
_____ Alcohol/Drug Treatment Information
_____ HIV Test Results (regardless of result)

PURPOSE OF THIS RELEASE: (Check all that apply)

☐ Personal Use ☐ Continuity of Care ☐ Billing ☐ Disability ☐ Insurance ☐ Legal
☐ Other (state reason): _____

Note: Fees may be associated with this request. Some records are unavailable to receive via MyChart.

It is my understanding that I have the legal right, with certain limitations, to either view or obtain copies of my protected 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 Print Name and relationship (if other than the patient) Date/Time

RUHS Health Information Management, Release of Information
7898 Mission Grove Parkway South, Suite 200, Riverside, CA 92508
Phone: 951.486.5040 Fax: 951-486-5075

FACILITY USE ONLY: Requested records sent on: _____ Completed by: _____

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Important Information Regarding My Rights

Notice: Riverside University Health System and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your protected health information (PHI) confidential. If you have authorized the disclosure of your PHI 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 Riverside University Health System - Health Information Management Department. 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 Health Information Management Department at 951-486-5040.