UC San Diego
MEDICAL CENTER

Patient Name _____

Date of Birth ____/____/_____

Phone # (_____) _____

MR# _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize _____ to release health information to:
Name of person or facility, which has information

Tracey Truscott, LCSW/Ivonne Arias, MSW
Name of person or facility to receive health information

Shiley-Marcos Alzheimer's Disease Research Center and Research Affiliates
Specify name/title of person to receive health information, if known

9500 Gilman Dr. m/c (0948) La Jolla, CA. 92093-0948
Street Address, City , State, Zip Code

(858) 822-4800 Fax: 858-246-1282 Extension: NA
Telephone Number

TYPE OF RECORD

☑ Medical ☐ Billing ☑ Radiology images (X-rays, etc.)

INFORMATION TO BE RELEASED

☑ Inpatient dictated records (Discharge summary, History & Physical, Progress notes, operative reports, consultations, laboratory, radiology, and other diagnostic reports)

☑ Outpatient dictated records (Office notes, consultations, operative reports, laboratory, radiology, and other diagnostic reports)

☐ Immunization Records

☐ Emergency Department Reports

Sensitive Information

☑ HIV Test Results _____ *Patient initials*

☑ Genetic Test Results _____ *Patient initials*

☑ Psychiatric treatment records _____ *Patient initials*

☑ Drug & alcohol abuse treatment records _____ *Patient initials*

SPECIFY THE APPROXIMATE DATES OF TREATMENT FOR INFORMATION SELECTED:

the last 2 years

UC San Diego
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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Identification

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

☐ Continuing medical care ☐ Inspection of record ☐ Insurance
☐ Legal matter ☐ Personal copy ☑ Other

Notice

UC San Diego Medical Center 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 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 health information to provide to a third party.

- I may revoke this authorization at any time, provided that I do so in writing and submit it to:

  UC San Diego Medical Center
  Health Information Services
  200 W. Arbor Drive, # 8825
  San Diego, CA 92103-8825

- The revocation will take effect when UCSD Medical Center receives it, except to the extent that UCSD Medical Center or others have already relied on it.

- I am entitled to receive a copy of this Authorization.

Expiration of Authorization

Unless otherwise revoked, this Authorization expires[1] on: _____.
(Insert applicable date or event)

Signature

_____ Date: _____
(Signature of Patient or Patient's Legal Representative)

_____ Time: _____ AM / PM
(Printed Name)

_____
Relationship to patient (if other than patient):

(Footnotes)

[1] *If no date is indicated, this Authorization will expire 12 months after the date of signing this form.*