



# Authorization for Release of Health Information

Expires upon one time release of information.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City, State ZIP: \_\_\_\_\_ Phone: \_\_\_\_\_

## I authorize UCI Medical Affiliates Inc. and its properties to release my health information to:

Self  Other (specify below):

Name: \_\_\_\_\_

Company/Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City, State ZIP: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_ FAX: \_\_\_\_\_

## Disclosed health information to include:

Imaging  Provider Notes  Lab Reports

Other: \_\_\_\_\_

### Patient Information

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. *I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.*

I understand that I have the right to revoke this authorization by sending a written notification to UCI Medical Affiliates. I also understand that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification.

Written notification may be sent to **medicalrecords@doctorscare.com**

Expiration Date/Event: \_\_\_\_\_

X  
\_\_\_\_\_  
Signature of Patient or Personal Representative Date

\_\_\_\_\_  
Description of Personal Representative's Authority (attach documentation as necessary)