BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO • SAN FRANCISCO

SANTA BARBARA • SANTA CRUZ

UNIVERSITY OF CALIFORNIA EYE CENTER

BERKELEY, CA.

Authorization for Release of Health Information

Patient Name: _____ **Date of Birth**: _____

I, _____

authorize _____
(Name of person or facility **which has information** – example: UC Eye Center)

to release health record information for:

_____
(patient name or self)

to: _____
(Name of person or facility **receiving** information)

The purpose of this release is for:
☐ Receiving care at UC Eye Center
☐ Discharge planning
☐ Other (please state):
_____
_____

Please specifiy the health information you authorize to be released:
Type (s) of health information: _____
Date (s) of treatment: _____

Would you like the records to be:
☐ Faxed
☐ Mailed
☐ In Person Pick-Up at UC Eye Center

☐ Please send the records to:
Name: _____
Address: _____
_____
Phone: _____
Fax: _____

OR

☐ Send records to:
UC Eye Center
200 Minor Hall
Berkeley CA 94720-2020
Phone: (510) 642-2020
Fax: (510) 642-8012

NOTICE

UC Eye Center and other health organizations 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.

YOUR RIGHTS

- This Authorization to release health information is voluntary. Treatment, payment, and eligibility for benefits may not be conditioned on signing this Authorization except for the following cases: (1) to conduct 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.
- This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to clinic Privacy Officer, at UC Eye Center, 200 Minor Hall, Berkeley, CA 94704-2020. The revocation will take effect when UC receives it, except that others or we have already relied on it.
- You are entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires:_____(insert applicable date or event). If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

_____ _____
Print Name Date

_____ _____
Signature (Patient, Parent, Guardian) Relationship to Patient (Parent, Guardian, or Patient Representative)

For Internal use: Information release: Initials _____ Date _____
Copy of authorization to patient: Initals _____ / Authorization Revoked Date _____