UNIVERSITY
HEALTHCARE ALLIANCE

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

A. This authorization is for use or disclosure of health information pertaining to:

*Patient's Name: Last*_____ *First* _____ *MI*____
*Address*_____ *MRN#*_____
*City*_____ *State* _____*Zip*_____
DOB *Phone#* *Cell#* *Fax#*
(Incomplete information may invalidate this authorization)

B. I hereby authorize:

*Name of Person or Organization Releasing Information*_____
*Address*_____
City *State* *Zip*

C. To disclose health information to:

*Name of Person or Organization Receiving Information*_____
*Address*_____
*City*_____ *State*_____ *Zip*_____
*Phone#*_____ *Fax#* _____
Paper ☐ *CD* ☐

D. The purpose of this release is to (check one or more):

☐ At the request of the Patient/Patient Representative. _____
☐ Other (state reason): _____

E. This authorization applies to the following information:

☐ Medical Records (**Specify** document(s)):
☐ All records (**Specify** date(s)): to
☐ Radiology & Other Diagnostic Images ☐ Labs ☐ Consultations / Evaluations
☐ I will pick up ***or*** Mail to the above address
☐ Billing Records – If requesting **UHA** Billing Records only: Please mail this request directly to the Billing Department UHA: 24301 Southland Dr. suite 300 Hayward, CA 94545
Fax# (510) 731-2695 (**Specify** date(s) of service):

F. Specific authorization is required to disclose information regarding the following:

(Check box and sign below to specify information is to be disclosed):

☐ Psychiatric/Mental Health ☐ HIV Lab Test Results
☐ Drug /Alcohol Abuse ☐ Genetic/Fertility
Signature:

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G. My Rights

• I may refuse to sign and my refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
• I authorize _____ to pick up my protected health information.
• I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
• This authorization shall become effective immediately and shall remain in effect for 1year from date of signature unless otherwise noted.
• I reserve the right to withdraw or revoke this authorization, in writing, at any time, except to the extent that University HealthCare Alliance has already disclosed the information.

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization. Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not Prohibited by California law and may no longer be protected by federal confidentiality law (**HIPAA**). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specially required or permitted by law.

_____

H. *Signature:* _____ *Print Name:* _____
(*Patient/Legal Representative)*

Date: _____ *Time*: _____ *am/pm*

Relationship to Patient: _____

_____

Office Use Only:

Site: _____

MRN # _____