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, _____
(Patient name)

Authorize _____
(Name of person or facility which has information-example: UC Eye Center)

To release health record information for:

_____
(Patient name)

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 specify the health information you authorize to be released:

Type (s) of health information: _____

Date (s) of treatment: _____

Would you like the records / photos to be:

- ☐ Faxed
- ☐ Mailed
- ☐ In Person Pick-Up
- ☐ E-mailed*

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

*Consent to send records or photos Via E-mail - E-mail is not HIPAA Compliant

I voluntarily give my permission to the Meredith Morgan University of California Eye Center /Tang Eye Center at University Health to send records via E-mail. I give this permission understanding the e-mail may be unencrypted and therefore is not secure. E-mail contents and attachments may be read by unintended recipients.

I DO / DO NOT give permission to e-mail records using this address: _____ **Initial:** _____

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 aa third party.
- This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your patent 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.
- 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 of Patient, Parent or Guardian **Relationship to patient**

For Internal Use: Information release: Initials _____ Date_____

Copy of Authorization to patient: Initials _____ Date _____

Patient identity verified (circle one): State Issued ID Passport Signature Match Other_____ Initials_____