[redacted]

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

***Hospital & Clinic staff:**
Affix patient label here. If providing records to the patient, update the Staff Use section of the form and update Quick Disclosure.

Patient Identification

Patient Information:	Patient Name [redacted]		Nickname/Maiden/Other
	Address/City/State/Zip		
	Date of Birth [redacted]	Last 4 of SSN# [redacted]	Phone [redacted]
Record Holder: *Who has the information you want released?*	☐ UC San Diego Health ☑ Other: Cruse Maria B MD		
	Address/City/State/Zip: 604 N Acadia rd #201		
	Phone: 985 493 9304	Fax (Urgent Patient Care only)	
Release Records to: *Where do you want records sent? Who do you want to receive records?*	Name of Hospital/Clinic/Persion [redacted]		
	Street Address/City/State/Zip [redacted]		
	Phone [redacted]	Fax (Urgent Patient Care only)	
Purpose:	☑ Continued Care – Appointment Date (if known): ____ / ____ / ____ ☐ Legal ☐ Personal ☐ Insurance ☐ Disability Other *(please specify)*:		
Health Information to be Released: *What do you want sent or released?*	Routine Record Sets – **For dates of service:** 2003 [redacted] - [redacted] 2012 ☐ **Hospital Stay** (History and physical, operative report, discharge summary, progress notes, lab, radiology reports) ☑ **Clinic visit** (office notes, procedure notes, operative notes, lab, diagnostic and radiology results) ☑ **Other Records –** *Please Specify Type:* Medication History - therapy Notes ☐ **Billing Records** ☐ **Radiology Images (only)** ☐ Mail ☐ Pick-up ☐ Email** (See bottom of page 2 for email limitation)		
Sensitive Information:	**Sensitive information WILL BE RELEASED unless you tell us not to by initialing below:** _____ Do Not Release Drug & Alcohol abuse treatment records _____ Do Not Release Mental Health/Psychiatric treatment records _____ Do Not Release HIV Test Results _____ Do Not Release Genetic Test Results		
Authorization	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 understand this authorization may be revoked in writing at any time except to the extent that action had been taken in reliance on this authorization. Unless otherwise revoked this authorization will expire 12 months after the date of signing this form.		

Signature of Patient or Authorized Representative	Print Name	Date	Time
[redacted]	[redacted]	9-12-18	2 AM/PM

Relationship (If signed by other than Patient)	If Interpreted: Signature OR ID of Interpreter ☐ Telephone ☐ Video	Language	Date	Time
				AM/PM

***Staff Use**	Info Released By: On Date: