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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) FOR MENTAL HEALTH/CHEMICAL DEPENDENCY

Check the box that applies: **Dates of Treatment:**_____

- ❑ Release my BMC records to:
- ❑ Obtain my records from:
- ❑ Release Billing Summary to:
- ❑ Patient Access: (Provide documentation if you are patient representative)
- ❑ Make records available for review: (Confirm record review appointment)

_____

Individual /Agency Name

_____

Address

_____

City State Zip Code

Records released are authorized for the following purpose:

☐ Continued Care ☐ Personal Use ☐ Other _____

I understand authorizing the disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____
If I fall to specify an expiration date, event or condition, this authorization will expire 90 days from the date of signature.
I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Medical Record Department.

Patient Name: _____ _____ _____DOB:_____
Last First M.I.

SS#: _____Phone #: _____

_____ _____ _____
Signature of Patient or Legal Representative Date Relationship to Patient

LOMA LINDA UNIVERSITY BEHAVIORAL MEDICINE CENTER

AUTHORIZATION FOR RELEASE OF PHI FOR MENTAL HEALTH/ CHEMICAL DEPENDENCY

BMC 1038 Rev. 4/2003
500 01/21/05

White -facility Pink-Patient

PATIENT IDENTIFICATION