Effective as of January 1, 2006
Please send all completed forms to:

Mailing Address:

UC Davis Health System
Health Information Management
Medical/Legal Release of Information Unit
2315 Stockton Blvd.
Building #12
Sacramento, CA 95817

Or via

Electronic Communications:

him@ucdmc.ucdavis.edu

Or via

Fax:

(916) 734-2126

For additional information please call:
(916) 734-5205

PATIENT NAME_____

MEDICAL RECORD #:_____

BIRTHDATE:_____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize: _____

Name of person and/or facility which has information

_____

Street Address, City, State, Zip Code

to release health information to:

_____

Specify name/title of person and/or facility to receive health information

_____

Street Address, City, State, Zip Code

_____

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Please specify the health information you authorize to be released:

☐ MEDICAL

☐ MENTAL HEALTH (other than psychotherapy notes)

Type(s) of health information: _____

Date(s) of treatment:_____

You may also authorize the release of information for treatment provided after the date of the signature on this Authorization as long as such treatment occurs while this authorization has not expired. Please initial if you would like this Authorization to release information about healthcare you receive after the da

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PATIENT NAME_____

MEDICAL RECORD #:_____

BIRTHDATE:_____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

The purpose of this release is for (check one or more):

☐ At the request of the patient/patient representative

☐ Other (state reason) _____

NOTICE

UCDHS and many other organizations and indi