Patient Name

UCI Health

Sharing My Medical Information
Plain Language-HIPAA Authorization for Disclosure of Health Information

Sharing My Medical Information

(*Plain Language HIPAA Authorization for Disclosure of Health Information*)

My Information

My Name: _____ **My** Date of Birth: _____

My Address: _____

City: _____State: _____ Zip Code: _____

My Phone number: (_____) _____-_____

My Doctor

My doctor's office or **hospital** is called: _____

Address: _____

City: _____State: _____ Zip Code: _____

My doctors and other care providers write notes about me regarding my treatment and document any testing that has been done.
These notes are referred to as **medical records or records.**

I am wanting to share my records because of:
_____My Own Personal Use _____So My Parent / Support Person Can Help Me

Other(Please write why)_____

The person who can see and have copies of my records is:

Name: _____

Address: _____

Phone number: (_____) _____-_____

Email address: _____@_____._____

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Sharing My Information

This person can see:
Check all the boxes that you want records released.

☐ All of my medical records.

Sensitive information will not be released *unless* checked below:

☐ Drug / Alcohol Abuse Treatment
☐ HIV
☐ Genetic Information
☐ All of my Mental Health / Psychiatric records.

☐ Only some records.
The only records this person **can see** and have copies of are:

_____
_____
_____

This person can see my records until this date:_____, or for 5 years, unless I sign a form that says this person can no longer see my records.

I know that I do not have to share these records. My doctors and other health care providers will still treat me even if I don't sign this agreement.

-I know that I can stop this agreement at any time by signing a form with my doctor's office. If I stop this agreement, I know that the records already shared will not be returned.

-My doctors, and other care providers have to be very careful with my medical records. They cannot share my records with other people unless I agree. The person who I am sharing my records with cannot share them with other people unless I agree. If I share my records with someone who is not a doctor, that person may not be required to keep my records private.

-I trust the person I am sharing my records with.

My Signature:

My signature:_____

The date today is: _____

My Representative's Signature (if required)

_____Date: _____Time: _____AM/PM
Patient's Representative Signature

Relationship to Patient_____Reason for Non-Patient Signature: _____

_____ _____
Witness Signature Witness Print Name

Date: _____ Time: _____ AM / PM

If Interpreted: _____ _____ Date: _____

Time: _____ AM / PM Language

☐Telephonic ☐ Video Interpreter **or** ID#