IMPORTANT INFORMATION ABOUT REQUESTING HOSPITAL BILLING RECORDS

Records can be released to anyone who the patient authorizes (in writing) to receive such information. The UC Irvine Medical Center authorization form or any HIPAA compliant authorization form can be used to request hospital billing records.

A valid authorization MUST contain the following information or the request will be returned:

- Patient's full name and date of birth (list any other names or other information for identification)
- Who (by name or class of persons) is authorized to disclose the information (UCI Medical Center)
- To whom the information is to be sent (name and address)
- Specific information being requested (i.e., dates of service, payments, etc.)

  Sensitive information: Certain information requires a special authorization, including psychiatric, drug and/or alcohol abuse, HIV/AIDS, genetic testing. Authorizations for sensitive information must specifically refer to the information that is to be released.

- Purpose for which the information may be disclosed (i.e., personal use, legal matter)
- The authorization must also include the following notifications to the individual:
  - The individual may revoke the Authorization in writing and indicate how to do so
  - Treatment, payment, enrollment or eligibility for benefits may not be conditioned on the patient signing the Authorization
  - Information may be re-disclosed by the person receiving the records, and in that case, the confidentiality of the information is no longer protected
  - The patient, or the patient's legal representative, has a right to receive a copy of the authorization form
- Specific expiration date (otherwise, authorization will be valid one year from date signed)
- The patient's signature or a patient's legal representative's signature.
- If signed by patient's legal representative, signature/relationship must be verified. Please include a copy of one of the following documents:
  - Legal guardianship papers/relationship to unemancipated minor
  - Advance Directive/Healthcare Power of Attorney
  - Death certificate or evidence of next of kin or executorship for deceased patient
- Date of the signature

Authorized requests for hospital billing records may be submitted in person, by mail or by facsimile to:

Custodian of Financial Records
UC Irvine Medical Center, Route 123
200 S. Manchester, 4th Floor
Orange CA 92868

Telephone: 714/456-6338
Facsimile: 714/456-7497

UCI Medical Center
AUTHORIZATION FOR RELEASE
OF HEALTH INFORAMTION

Medical Record Number:

Patient Name:
Date of Birth:

I authorize UCI Medical Center to release health information to:

Name of person or facility to receive health information

Specify name/title of person to receive health information, if known

Street Address, City, State, Zip Code

Phone number

INFORMATION TO BE RELEASED

☐ Discharge Summary	☐ Laboratory Reports	☐ Emergency Medicine Reports
☐ Billing Statements	☐ Dental Records	☐ History & Physical Exams
☐ Pathology Reports	☐ Operative Reports	☐ Diagnostic Imaging Reports
☐ EKG	☐ Radiology Reports	☐ Consultations
☐ Progress Notes		☐ Outpatient Clinic Records
☐ Vaccinations/Immunizations		
☐ Other _____		

SPECIFY THE DATE OR TIME PERIOD FOR INFORMATION SELECTED ABOVE

_____

SPECIFIC AUTHORIZATIONS

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:

☐ I specifically authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment (42 C.F.R. §§2.34 and 2.35).

☐ I specifically authorize the release of information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code §§5328, *et seq.*)

☐ I specifically authorize the release of HIV/AIDS testing information (Health and Safety Code §120980(g)).

☐ I specifically authorize the release of genetic testing information (Health and Safety Code 124980(j)).

THE PURPOSE OF THIS RELEASE IS (check one or more)

- ☐ Continuity of care or discharge planning
- ☐ Billing and payment of bill
- ☐ At the request of the patient/patient representative
- ☐ Other (state reason)

NOTICE

UCIMC and many other organizations and individuals such as physicians, hospitals and health plans 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.

MY RIGHTS

- 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) obtaining information in connection with eligibility or enrollment in a health plan for 3) to determine an entity's obligation to pay a claim, or 4) to create health information to provide to a third party. Under no circumstances, however, am I required to authorize the release of mental health records.
- I may revoke this authorization at any time, provided that I do so in writing and submit it to UCIMC c/o Health Information Management, Rt. 118, Bldg.25, Orange, CA 92868. The revocation will take effect when UCIMC receives it, except to the extent that UCIMC or others have already relied on it.
- I am 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, this authorization will expire 12 months after the date of signing this form.

Personal Use

I understand I will be charged a per page fee for copies produced for my personal use.

_____
Initial

SIGNATURE

_____ Date: _____
(Signature of Patient or Patient's Legal Representative)

_____ Time: _____ AM / PM
Printed Name

_____
(If signed by someone other than the patient, state your legal Relationship to the patient/authority)

_____
Witness or Translator

Form 81610
(Rev. 05/04)

UNIVERSITY of CALIFORNIA · IRVINE HEALTH AFFAIRS

200 S. Manchester Avenue
Suite 400
Orange, CA 92868-3201

Patient financial (billing) records and medical records are under separate custodianship at UC Irvine Medical Center. Physician/Professional records are also under separate custodianship.

If you wish to request UC Irvine Medical Center (facility) financial/billing records, contact us:

Custodian of Financial Records
Patient Financial Services
UC Irvine Medical Center, Route 123
200 South Manchester, 4th Floor
Orange CA 92868

Telephone: 714/456-6338
FAX: 714/456-7497

Hours for pick up: Mon –Fri, 8:00am to noon, 1:00 pm to 4:00 pm

If you wish to request medical records(charts,md notes,x-rays, etc) please contact:

Health Information Services
UC Irvine Medical Center, Route 118
101 The City Drive South, Bldg.25
Orange CA 92868

Telephone: 714/456-5670
FAX: 714/456-7576

If you wish to request Physician/Professional Fee financial records, please contact:

UC Irvine HealthSystems
UC Irvine Medical Center, Route 192
200 South Manchester, 3rd Floor
Orange CA 92868

Telephone: 714/456-8787
FAX: 714/456-6298