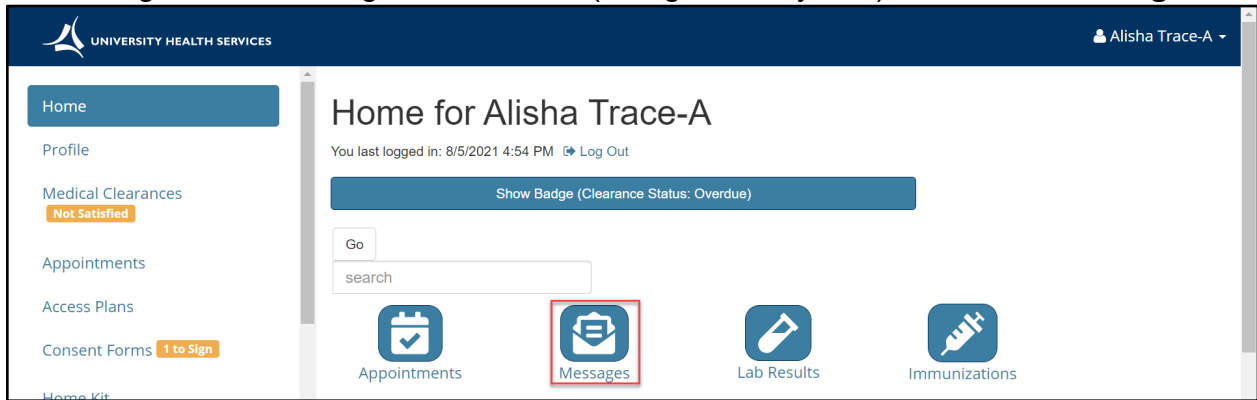
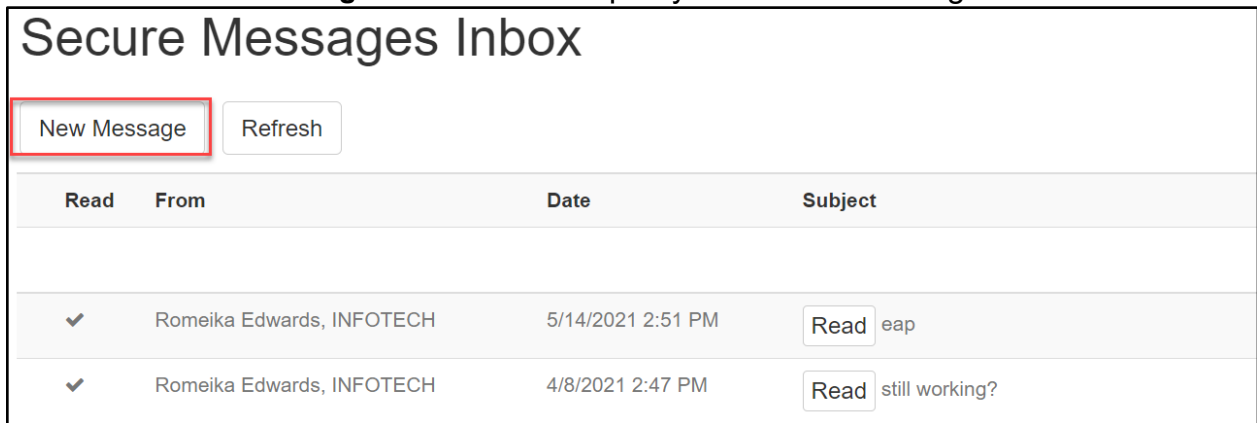


How to Submit a Release of Information (ROI) Request

1. Log in to the eTang Patient Portal (etang.berkeley.edu) and select **Messages**

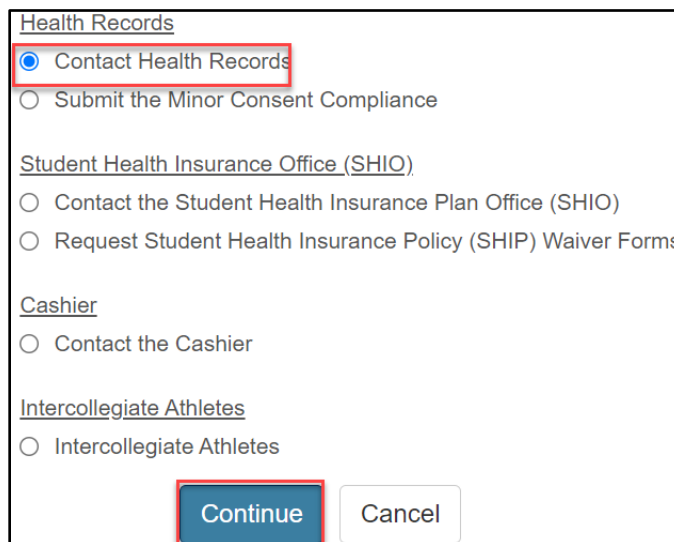


2. Click **New Message** located at the top of your Secure Message Inbox



3. Locate the **Health Records** section and choose **Contact Health Records**

4. Continue



5. Health Records Release of Information Request

How to Submit a Release of Information (ROI) Request

Please select which type of message you would like to send Health Records?

If you are requesting a copy of ANY of your medical records, you must complete an Authorization form on the following page.

Select One

- General Inquiry to Health Records
- Health Records Release of Information Request
- Intercollegiate Athletics Release of Information for Sports Medicine
- Minor Consent form upload
- COVID Vaccination Questions
- Return to Message Options

Continue

Cancel

6. Select the appropriate Release of Information option. Enter details for the organization including Name, Address, Phone number and Fax.

Compose New Secure Message

Please allow at least 15 days for processing.

All messages become part of your legal health record.

Recipient: HEALTH RECORDS, PROVIDER GROUP

Message Type: Health Records ROI

Subject: Authorization to release health records

Attachments: Add attachment...

Items marked with **are required.

Authorization for Release of Health Information

**** Authorization**

Patient hereby authorizes University Health Services to (check all that apply):

Release Information to: Mutually Exchange Verbal Information with: Request Information from:

**** Include Name, Address, Phone and Fax**

Health Organization 123 Health St. Berkeley, Ca 94704 phone: 510-555-5555 fax: 510-444-4444

7. Confirm the disclosure type (Verbal or Electronic Copy of Record) for the health record

Type of disclosure

Verbal communication

Copies of Records (**Note - when possible, and unless otherwise requested, copies will be released electronically via USB drive)

8. Check the record(s) that is being released.

How to Submit a Release of Information (ROI) Request

Health Information Authorized to be Released (Please check all that apply.)

Immunization records (does not include Mandatory TB/Immunization Program Records)

Radiology Records

Laboratory Results

Insurance Referrals

Billing records

Counseling and Psychological Services (CAPS) Records

Psychiatry Records

SHIP Waiver Information (applies to verbal disclosure only)

Social Services Records


Behavioral Health Records (connected to services in primary care; not related to CAPS)


MEDICAL RECORDS (May include incidental drug/alcohol and behavioral health information documented entire visit note that contains such information. Medical records do NOT include counseling, psychiatry, Other (Specify):

9. Indicate the dates of treatment time period for the records being released otherwise the last two years of records will be released.

10. Indicate the Purpose of Release

Specify date(s) of treatment or time period. (**Note - Unless otherwise specified, only the last two (2) years of records are released.)

From 

To: 

Or enter a time period:

*For questions about the release of Counseling and Psychological Services or Social Services records please contact CAPS Records at (510) 642-9494 or Social Services at (510) 642-6074.

Purpose of Release
Please state the purpose for the request.

Continuity of Care

Insurance Purpose

Legal Matter

Personal Use

Other (please specify):

11. If requesting to release info regarding HIV/AIDS testing or Genetic Testing info, complete the 'Specific Authorization' section.

12. Complete the Expiration and Validity of Authorization Date otherwise the authorization will expire 12 months after the date of request.

How to Submit a Release of Information (ROI) Request

Expiration and Validity of Authorization

Unless otherwise revoked, the Authorization is effective immediately and shall remain in effect until



If no date is indicated, this Authorization will expire twelve (12) months after the date of requestor's submission of this form.

13. Review the summary regarding your Rights

14. Click '**Send**' to submit Release of Information.

Please read the important notice concerning your rights

Notice: UHS 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.

YOUR RIGHTS: This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct 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.

This Authorization may be revoked at any time using the appropriate form available at the Medical Records department or online [HERE](#). The revocation form must be signed by you or your patient representative, and delivered to Medical Records Department, University Health Services, 2222 Bancroft Way, Berkeley, CA 94720-4300. The revocation will take effect when UHS receives it, except to the extent UHS or others have already relied on it.

You are entitled to receive a copy of this Authorization upon request.

Send

Cancel

The following message will appear upon submission of request:

Secure Messages Secure Message Sent

Your message has been sent.

Proceed

Note: Please allow 15 business days for request