UNIT NUMBER

PT. NAME

BIRTHDATE

LOCATION DATE

UCSF Medical Center

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize ______________________________
(Name of person or facility which has information)
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

____
Fax Number (if information is to be faxed)

The purpose of this release is for (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)

Please specify the health information you authorize to be released:

Type(s) of health information: ______________________________

Date(s) of treatment: ______________________________

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

- ☐ Information pertaining to drug and alcohol abuse, diagnosis or treatment (42 C.F.R. §§2.34 and 2.35).
- ☐ Information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code §§5328, *et seq.*)
- ☐ Release of HIV/AIDS test results (Health and Safety Code §120980(g)).
- ☐ Release of genetic testing information (Health and Safety Code §124980(j)).

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires ____________(insert applicable date or event). If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

____
Print Name

____
Signature (Patient, Parent, Guardian)

____
Date Time

____
Relationship to Patient (Parent, Guardian, Conservator, Patient Representative)

____
Witness (only if patient unable to sign) or Interpreter

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