UCSF Health
Medical Foundation

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

DATE:

PATIENT NAME:

BIRTHDATE:

ID VERIFICATION (TYPE):

ID VERIFIED BY:

I authorize:

(Name of person or facility which has information – example: UCSF Health Medical Foundation)

Clinic Phone | Clinic Fax

to release health information to:

(Name of person or facility to receive health information and full address)

Street Address | City | State | Zip Code

Phone Number | Fax Number

☐ Check this box to authorize exchange between the persons/organizations listed above.

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

☐ Continuity of care or discharge planning ☐ Billing and payment of bill

☐ At request of the patient / patient representative ☐ Other (state reason):

Please specify the health information you authorize for release. (Check all that apply.)

For dates of service:

☐ Clinic/Office Visit ☐ Radiology Images (Only) ☐ Reproductive Health Clinic ☐ Billing Records

☐ Other Records (not listed above, please specify):

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 | Relationship to Patient (Parent, Guardian, Conservator, Patient Rep.)

Patient Phone Number

Requested format: ☐ Paper (Pick-up) ☐ Fax