



**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

UNIT NUMBER

PT. NAME

BIRTHDATE

LOCATION

DATE

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

756-020Z (04/03)

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**NOTICE**

UCSF 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. The revocation must be in writing, signed by you or your patient representative, and delivered to: Health Information Management Services, UCSF Medical Center, 400 Parnassus Ave., Room A68, San Francisco, CA 94143-0308. The revocation will take effect when UCSF receives it, except to the extent UCSF or others have already relied on it.

You are entitled to receive a copy of this Authorization.