UCSF Health

DATE:

PATIENT NAME:

BIRTHDATE:

ID VERIFICATION (TYPE):

ID VERIFIED BY:

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize: _____
(Name of person or facility which has information - example: UCSF/Mt. Zion)

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

Street address City State Zip Code

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

Please specify the health information you authorize to be released. Please check all that apply.

For dates of service: _____

☐ **Emergency Room Visit** (e.g. ED provider notes, radiology reports, lab and diagnostic, consults and procedure notes)

☐ **Entire Hospital Record** (e.g. History and physical, consult, operative report, discharge summary, lab, radiology reports, nursing notes, progress notes)

☐ **Clinic or Office Visit** (e.g. Progress notes, office notes, procedure notes, operative notes, lab, diagnostic and radiology reports)

☐ **Billing Records** ☐ **Radiology Images (only)** ☐ **Dental Clinics** ☐ **Reproductive Health Clinic**

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

Delivery Method (*please select one*): ☐ Mail ☐ Pick-up ☐ Online Portal (Medical Records Only)

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)

Patient Phone Number

Patient Email

Date Time

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

Requested format: ☐ Paper ☐ CD

756-0202I (Rev. 04/22) MEDICAL RECORD COPY

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.

SAN FRANCISCO PATIENTS

Return Completed Authorization To:
Health Information Management Services
UCSF Medical Center
400 Parnassus Ave., Room A88
San Francisco, CA 94143-0308

OAKLAND PATIENTS

Return Completed Authorization To:
Health Information Management Services
747 52nd Street
Oakland, CA 94609

RADIOLOGY REQUESTS:

Return Completed Authorization To:
Email: RadiologyFilmLibrary@ucsfmedctr.org
Fax: 415-353-8583
If you have any questions about obtaining a copy of your images and report, please call the Radiology Imaging Library at (415) 353-1640 (opt. 3), 7:00 a.m. to 6:00 p.m., open seven days a week.

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. 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.

Made accessible
7/23