UCSF Benioff Children's Hospital Oakland

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)**

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

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

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