

DATE:	ID VERIFICATION (TYPE)
PATIENT NAME:	
BIRTHDATE:	ID VERIFIED BY:

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Γ		The manager of this male and in	
	I authorize (Name of person or facility which has information - example: UCSF/Mt. Zio to release health information to: Name of person or facility to receive health information (full address)	The purpose of this release is for (check one or more):	
		Continuity of care or discharge planning	
		alth ☐ Billing and payment of bill	
	Street address:	At the request of the patient/ patient representative	
		Other (state reason)	
	City, State, Zip Code		
	Please specify the health information	-	
\bigcirc	Type(s) of health information:		
	Date(s) of treatment:		
\supset	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 (4 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)).		
RD COPY	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.		
IEDICAL RECO	Print Name	Signature (Patient, Parent, Guardian)	
500-0559 (Rev. 11/18) MEDICAL RECORD COPY	Date Time	Relationship to Patient (Parent, Guardian, Conservator, Patient Representative)	
200-02	Requested format: Paper CD		



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.

Return Completed Authorization To:

Prima Medical Foundation Release of Information 9 Commercial Blvd., Ste 200 Novato. CA 94949

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. 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.