

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

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

OF HEALIH INFORMATION				
I authorize:				
(Name of person or facility which has information - example of person or facility which has information - example of person or facility which has information - example of person or facility which has information - example of person or facility which has information - example of person or facility which has information - example of person or facility which has information - example of person or facility which has information - example of person or facility which has information - example of person or facility which has information - example of person or facility which has information - example of person or facility which has information - example of person or facility which has information - example of person or facility which has information - example of person of person or facility which has information - example of person or facility which has information - example of person or facility which has information - example of person or facility which has not person or facility w	mple: 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	-	organizations li		•
The purpose of this release is for (check or	ne or more):			
Continuity of care or discharge planning	•	wment of bill		
☐ At the request of the patient/patient represe		-	า):	
Please specify the health information you a	uthorize to be re	leased Please	check a	II that annly
For dates of service:	difforize to be re-	icasca. i icasc	CHECK &	iii tiiat appiy.
☐ Emergency Room Visit (e.g. ED provider notes	. radiology reports, lab	o and diagnostic.	consults ar	nd procedure no
☐ Entire Hospital Record (e.g. History and physical Property of the Control of t		•		·
reports, nursing notes, progress notes)	siedi, eeriedit, eperati	10.000.0	go carrirre	a. y, .a.o, .a.oo.e
Clinic or Office Visit (e.g. Progress notes, offi	ce notes, procedure	notes, operative i	notes, lab,	diagnostic and
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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.

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.