UCSF Benioff Children's Hospital
Oakland

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

747 52nd Street, Oakland, California 94609
Telephone: (510) 428-3730 | Fax: (510) 658-1923

Patient Name: ______________________ ______________________ ______
Last Name First Name M.I.

Date of Birth: _______/_______/_______ **MR/UNIT#:** ____________

I authorize: ☐ UCSF Benioff Children's Hospital Oakland
☐ Other: ______________________________
Name of Person or Organization Releasing Information

to release/disclose health information to:

____
Name of Person or Organization Receiving Information

____
Mailing Address

____
City State Zip Code

The Purpose of this Release is for (check all that apply):

☐ Medical Care
☐ Insurance
☐ Legal Claim
☐ Patient/Personal
☐ Other (List): ______________

☐ Check this box to authorize exchange between the persons/organizations listed above

Information Requested (check all that apply):

☐ Pertinent Summary (discharge summary, history & physical, operative, pathology, consultation, radiology reports, labs & EEGs) ☐ Emergency Record ☐ Clinic Records ☐ Immunizations ☐ Other:

Date(s) of Treatment: ☐ From ____________ to ____________ ☐ All dates of service

The following information WILL NOT BE RELEASED unless you specifically authorize it by checking the appropriate box(es) below:

☐ Drug / alcohol diagnosis or treatment information
☐ Mental health diagnosis or treatment information
☐ Reproductive health including pregnancy and sexually transmitted disease, HIV/AIDs status.
☐ Genetic testing information

Please provide the records ☐ Paper ☐ Electronically (CD)

Expiration of Authorization

Unless otherwise revoked, this authorization expires on ____________or 12 months after the date of my signing this form. I understand:

- This authorization may be revoked in writing at any time, except to the extent that Children's has already disclosed the information. I must submit my revocation to UCSF Benioff Children's Hospital Oakland, HIM Department, 747 52nd Street, Oakland, CA 94609
- I may refuse to sign this authorization. Treatment may not be withheld or conditioned on obtaining this authorization.
- If disclosure of this health information is to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected.
- I have a right to receive a copy of this authorization.

______________________ ____________ ______________
Signature Date Area Code and Phone Number

If signed by other than patient, indicate legal relationship: ____________________

Revised 11/14/16