



THE ARCHDIOCESE OF SAN FRANCISCO  
 ONE PETER YORKE WAY, SAN FRANCISCO, CA 94109-6601

**AUTHORIZATION FOR RELEASE  
 OF HEALTH INFORMATION**

<p>I authorize _____  <small>(Name of person or facility which has information - example: UCSF/Mt. Zion)</small>          to release health information to:</p> <p>_____</p> <p>Name of person or facility to receive health information (full address)</p> <p>_____</p> <p>Street address, City, State, Zip Code</p> <p>_____</p> <p>Phone number _____ Email _____</p> <p>_____</p>	<p><b>The purpose of this release is for (check one or more):</b></p> <p><input type="checkbox"/> Continuity of care or discharge planning</p> <p><input type="checkbox"/> Billing and payment of bill</p> <p><input type="checkbox"/> At the request of the patient/patient representative</p> <p><input type="checkbox"/> Other (state reason) _____</p> <p>_____</p> <p>_____</p>
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**Please specify the health information you authorize to be released:**

Type(s) of health information: \_\_\_\_\_

Date(s) of treatment: \_\_\_\_\_

**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.

<p>_____</p> <p>Print Name</p> <p>_____</p> <p>Date</p> <p>_____</p> <p>Date of Birth</p>	<p>_____</p> <p>Signature (Patient, Parent)</p> <p>_____</p> <p>Relationship to Patient (Parent, Patient Rep)</p> <p>_____</p> <p>Witness (only if patient unable to sign) or Interpreter</p>
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