**CONSENT TO DISCLOSE FORM**

**Note: This form is used to confirm a Member's permission that the Insurance Company and/or its representatives ("Health Plan") may discuss or disclose his/her plan eligibility information to a representative of the University of California, San Francisco (UCSF), for the sole purpose of verifying the existence of qualifying comparable coverage as set forth by UCSF. Use of the information collected on this form is strictly limited to that purpose described above.**

**Section A: Student Information**

By signing this form in Section D below, I understand and agree that you, UCSF may inquire from the named Insurance Company (section C) and/or its representatives regarding my enrollment and eligibility in a health insurance plan. I understand and agree that by signing Section D below I am consenting to the disclosure of this protected health information to UCSF.

Student Name: DOB (MM/DD/YY):

Address:

Telephone Number: ( ) Student ID Number:

E-mail Address:

**Section B: Type of Information**

- Protected Health Information limited to: enrollment and eligibility status, dates of coverage, and benefits available under the policy.

**Section C: Authorized Use and / or Disclosure**

**Intended Use or Disclosure:**
I understand that your general policy is not to disclose my protected health information to other parties, except those directly involved in my care, without my written authorization or as permitted or required by law. For this reason, I authorize the Health Plan named below to discuss and disclose my protected health information to representatives of UCSF for the purpose of verifying my enrollment and eligibility for benefits under the Policy issued by the Insurance Company.

**Insurance Company/Health Plan:**

Name: Phone Number: ( )

Address:

Policy Number:_____ Member ID Number _____

Effective Date of Policy: _____

**Section D: Signature / Authorization**

I have had full opportunity to read and consider the content of this Consent to Disclose Form. I confirm that this authorization is consistent with my request of the Health Plan and its administrator(s). I understand that, by signing this form, I am confirming my authorization that the Health Plan may use and/or disclose my protected health information to the representatives of UCSF for the purpose described above.

**Signature:** **Date:**

**Return Form to:** UCSF Student Health Service, 500 Parnassus, Box 0722, MUH 005,
San Francisco, CA 94143