STUDENT HEALTH & COUNSELING SERVICES
500 Parnassus Ave., MU-H005, San Francisco, CA 94143-0722
Phone (415) 476-1281 Fax (415) 476-6137

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name _____Date of Birth_____
Last 4 digits of SSN#_____Request Date_____

I hereby authorize: _____
(Name of person or facility which has information)

to release to:

_____
(Person, Physician, Hospital or Clinic to receive information)

_____
Address

_____
City State Zip Code

Fax Number (if information to be faxed)_____

Please specify the health information you authorize to be released:	The purpose of this release is for (Check one or more):
_____ Type(s) of Treatment: _____ Date(s) of Treatment:	❑ Continuity of care or discharge planning ❑ Billing and payment of bill ❑ Other (state reason)_____ _____

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 §§5328m 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)).

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Expiration of Authorization.
Unless otherwise revoked, this Authorization expires on _____ (insert applicable date or event). If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

_____	_____
Print Name	Signature (Patient or Authorized Representative)
_____	_____
Date	Relationship, if person other than patient signs
	_____
	Witness, if patient unable to sign or Interpreter

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, state or federal confidentiality laws may no longer protect it.

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: Student Health & Counseling Services (SHCS), 500 Parnassus Ave., Room MU-H005, San Francisco, CA 94143-0722. The revocation will take effect when SHCS receives it, except to the extent SHCS or others have already relied on it.

You are entitled to a copy of this Authorization.