eastbaypediatrics
2999 Regent Street, Suite 325, Berkeley, CA 94705
96 Davis Road, Suite 2, Orinda, CA 94563
(925) 438-1100
www.eastbaypediatrics.com

DATE:

PATIENT NAME:

BIRTHDATE:

ID VERIFICATION (TYPE):

ID VERIFIED BY:

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize _____
(Name of person or facility which has information - example: Hilltop Pediatrics)

_____

to release health information to:

_____

Name of person or facility to receive health information (full address)

_____

Street address:

_____

City, State, Zip Code

_____

The purpose of this release is for (check one or more):

- ☐ Continuity of care or discharge planning
- ☐ Billing and payment of bill
- ☐ At the request of the patient/ patient representative
- ☐ Other (state reason)_____

_____

_____

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.

_____ _____

Print Name | Signature (Patient, Parent, Guardian)

_____ _____

Date Time | Relationship to Patient (Parent, Guardian, Conservator, Patient Representative)

Requested format: ☐ Paper ☐ CD ☐ Email ☐ USB ☐ Other:

NOTICE
UHMF 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.

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 the UBCP clinic you authorized to release your information. The revocation will take effect when the UBCP clinic receives it, except to the extent the UBCP clinic or others have already relied on it.

You are entitled to receive a copy of this Authorization.