UCSD *Healthcare*

UCSD OUTPATIENT PSYCHIATRIC SERVICES
140 Arbor Drive
San Diego, CA 92103
(619) 299-3510 • Fax (619) 497-6686

Print Patient's First and Last Name: _____

Social Security Number: _____ Date of Birth: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize UCSD Outpatient Services to release/ receive health information to/ from:

_____
Name of person and facility to receive/ supply health information.

_____
Street Address, City, State, Zip Code

(_____) _____
Telephone number Extension if applicable

TYPE OF RECORD *(check one or both)* __ Medical __ Mental Health

SPECIFY THE DATE(S) OR TIME PERIOD FOR INFORMATION SELECTED BELOW: _____

INFORMATION TO BE RELEASED *(check as many that apply)*

__ Physical Injuries, illnesses, or conditions
__ Mental, (Psychological/ Psychiatric) illness or condition
__ Alcohol/ Drug Treatment
__ Couples or Family Counseling *(note: Multiple release needed records may not be released without obtaining a signed consent from all parties who participated in counseling sessions recorded in this chart)*
__ HIV/ AIDS Test Results
__ Treatment Records
__ Other _____

THE PURPOSE OF THIS RELEASE IS: *(check one or more)*

_ At the request of the patient/ patient representative.
_ Other *(state reason)* _____

- I understand this authorization is voluntary. Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting 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.
- I may revoke this authorization at any time, provided that I do so in writing and submit to the clinic's address above.
- The revocation will take effect when UCSD Healthcare receives it, except to the extent that UCSD Healthcare or others have already relied on it.
- I am entitled to receive a copy of this Authorization.

Notice: UCSD Healthcare 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.

By signing below, I acknowledge that I have read and understand the information on this form.

_____ Date: _____
(Signature of Patient or Patient's Legal Representative) (Release expires 1 year from the above date)

_____ Date: _____
(CLINICIAN Authorization if needed)

7/03