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, 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: Langley Porter Psychiatric Hospital & Clinics, Medical Record Services, Box MRD –0984, 401 Parnassus Avenue, San Francisco, CA 94143-0984. The revocation will take effect when LPPH&C receives it, except to the extent LPPH&C or others have already relied on it.

You are entitled to a copy of this Authorization.

Authorization For Release Of Confidential Information Or Record
Subject To The Lanterman-Petris-Short Act And/Or
Federal Alcohol And Drug Abuse Regulations

Patient Name: _____
Date of Birth: _____
Medical Record No: _____

I hereby authorize _____
(LPPI or Other Institution/Clinician from whom information is being requested)

to release to: _____
Name of Person to Receive Information (Physician, Self, Therapist, Hospital, Clinic, etc)

_____
Address

_____
City State Zip Code
Fax Number (if information to be faxed). _____

Please specify the mental health information you authorize to be released:

_____
Dates of Treatment: _____
Form of Disclosure. ( ) Telephone ( ) Telephone & Fax ( ) Telephone & Paper Copy ( ) Paper Only

For release of fax or paper copy of record, the disclosure is limited to:
( ) Discharge Summary ( ) Discharge Summary & History/Physical ( )Entire Record
( ) Other: _____

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).
☐ Release of HIV/AIDS test results (Health and Safety Code §120980(g)).
☐ Release of genetic testing information (Health and Safety Code §124980(j)).

This disclosure is for: ( )Treatment ( ) Evaluation ( ) Legal ( ) Research ( ) Other _____

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.

Signed: _____ Date. _____
Patient or Authorized Representative

_____
Relationship, if person other than patient signs

Witness. _____ Date: _____

( ) Copy given to patient