UCSF Weill Institute for Neurosciences
Langley Porter Psychiatric Hospital

LANGLEY PORTER PSYCHIATRIC HOSPITAL

1600 Divisadero St.
San Francisco, CA 94143

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Name _____ Date of Birth _____

Phone _____ MRN _____

☐ **CHECK HERE IF YOU CONSENT TO AN EXCHANGE OF INFORMATION BETWEEN THE PARTIES BELOW**

Who has the information you would like released?	☐ UCSF Langley Porter Psychiatric Hospital & ☐ Clinics Other (Relationship to Patient: _____)		
	Name		
	Address:		
	City	State	Zip
	Phone:	Fax:	
To whom should the information be released?	☐ UCSF Langley Porter Psychiatric Hospital & Clinics ☐ Other (Relationship to Patient: _____)		
	Name		
	Address:		
	City	State	Zip
	Phone:	Fax:	

Information type(s) to be released:

☐ **Mental health information** (Lanterman-Petris-Short Act, WIC §5000 et seq.)
☐ **Medical** (Including drug/alcohol and mental health information documented by a primary care practitioner)
☐ **Drug and alcohol abuse, diagnosis or treatment information** (42 C.F.R. §§2.34 and 2.35)
☐ **HIV/AIDS test results** (Health and Safety Code §120980(g))
☐ **Genetic testing information** (Health and Safety Code §120980(g))

Limitations upon this disclosure: _____
Date(s) of treatment: _____
_____

Purpose of this release is:

☐ At the request of the patient/patient
☐ representative Other (state reason) _____

Unless otherwise revoked, this authorization expires _____ (indicate date or event).
If no date is indicated, the authorization will expire 24 months after the date of my signing this form.

_____ _____/_____/_____ _____ AM / PM
Signature (Patient, Parent, Guardian) Date Time

_____ _____
Print Name Relationship to Patient

_____
Witness (only if patient unable to sign) or Interpreter

NOTICE: LPPH&C 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) solely 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 client/patient representative, and delivered to Health Information Management Services, 401 Parnassus Ave, Box MRD 0984, 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 receive a copy of this Authorization.

If required for release of medical records (per Health Information Management Services):
The undersigned therapist, who is primarily responsible for the treatment of the patient, hereby (approves) (disapproves) the release of information to the party specified above. If disclosure is disapproved, give reason below and contact the Director of Patient Care Services. Also note below any restrictions on the release of records.

Reason for disapproval or restrictions:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____/_____/_____

Signature and Title Date

_____

Supervisor/Program Director's Signature and Title