City of South San Francisco
Medical Information
Release Form

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please submit a copy of a valid government issued photo identification of the patient listed on this form

Your Information		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS	CITY/STATE:	ZIP CODE:

Organization Providing the Information	Person/Organization Authorized to Receive the Information
Name: City of South San Francisco Address: 400 Grand Avenue City/State/Zip: South San Francisco, CA 94080 Phone #: (650) 877-8518	Name: _____ Address: _____ City/State/Zip _____ Phone # : (_____) _____ _____ Fax number: (_____) _____ _____ Email: _____
45 CFR § 164.508(c)(1)(ii), (iii) & Civ. Code § 56.11(c), (f)	

Description of the Information to be Released
(Provide a detailed description of the specific information to be released)
45 CFR § 164.508(c)(1)(i) & Civ. Code § 56.11(d), (g)

For the following period of time: from_____(date) to_____(date).

Description of the Purpose and Limitations for the Use or Release of the Information
(Indicate how information will be used)
45 CFR § 164.508(c)(1)(iv)

The information will not be used for any purpose other than its intended use.

- This authorization for release of the above information to the above named persons or organizations will expire on: _____ (date). [45 CFR § 164.508(c)(v) & Civ. Code § 56.11(h)]
- If no expiration date is specified, this authorization will expire three (3) years from the date of signature.

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I understand that:

- I authorize the use and/or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary. [45 CFR § 164.508(c)(2)(i)]
- Except to the extent information has been released in reliance upon this authorization, I have the right to revoke this authorization by sending a signed, written notice revoking this authorization to the City of South San Francisco at 400 Grand Avenue, South San Francisco, CA 94080. The authorization will cease on the date my valid written revocation request is received. [45 CFR § 164.508(c)(2)(i) & Civ. Code § 56.15]
- Treatment, payment, enrollment, or eligibility for benefits cannot be conditioned on signing this authorization. [45 CFR § 164.508(c)(2)(ii)]
- Under California law, the recipient of my medical information is prohibited from re-disclosing the information, except with a written authorization or as specifically required or permitted by law. [Civ. Code § 56.13]
- If the organization or person I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. [45 CFR § 164.508(c)(2)(iii)]
- I have the right to receive a copy of this authorization. [45 CFR § 164.508 (c)(4) & Civ. Code § 56.11(i)]
- Under California law, the recipient of records pertaining to outpatient psychotherapy treatment is required to return or destroy those records and all copies at the expiration date of this authorization. [Civ. Code § 56.104(a)(4)]

Patient Signature:	Date:

[45 CFR § 164.508(c)(1)(vi) & Civ. Code § 56.11(c)]

Representative Signature:	Relationship:	Date:

[45 CFR § 164.508(c)(1)(vi) & Civ. Code § 56.11(c)]

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