SAN MATEO COUNTY HEALTH
SAN MATEO
MEDICAL CENTER

Authorization for Release of Patient Information

I hereby authorize
Disclosing party: ______________________________
Address: ______________________________
City/State/Zip: ______________________________

To disclose to
Name of recipient: ______________________________
Address: ______________________________
City/State/Zip: ______________________________
Phone/Fax: ______________________________

Medical records/information pertaining to

Patient name ____________________ MR No. ____________________
Date of birth ____________________ Phone No. ____________________
Address ______________________________

Medical records/information to be disclosed

_____ Medical _____ Mental Health _____ Drug/Alcohol _____ HIV blood test

Other (include dates) ______________________________

Purpose of disclosure
- □ At the request of the patient
- □ Other ______________________________

Revocation: This authorization is subject to written revocation at any time. The revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon it. **Re-disclosure**: I understand that the recipient may not lawfully further use or disclose this information unless another authorization is obtained or unless such use or disclosure is specifically required or permitted by law. **Voluntary authorization**: Authorization to release health information is voluntary. Treatment, payment, or operations will not be conditioned on signing an authorization. **Copy**: You are entitled to receive a copy of this authorization. Please see your *Notice of Privacy Practices* for a complete list of your rights. **Duration**: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here: ______________________________.

Signature ______________________________ Date ______________________________

Relationship (if other than patient) ______________________________

Form # 11194 Rev. (09/18)

NOTICE

San Mateo Medical Center is required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not required to keep it confidential, it may not be protected by state or federal confidentiality laws.