THE ARCHDIOCESE OF SAN FRANCISCO
ONE PETER YORKE WAY, SAN FRANCISCO, CA 94109-6601

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize _____
(Name of person or facility which has information - example: UCSF/Mt. Zion)
to release health information to:
Vicar for Clergy or his Representative
Name of person or facility to receive health information (full address)
Care Managers: Rachel Alvelais or Mary D'Aquila, MSW
Street address, City, State, Zip Code
One Peter Yorke Way, SF, CA 94109

Phone number	Email
Rachel: 415-297-2549	alvelaisr@sfarch.org
Mary: 415-793-2709	daquilam@sfarch.org

The purpose of this release is for (check one or more):

- ☐ Continuity of care or discharge planning
- ☐ Billing and payment of bill
- ☐ At the request of the patient/ patient representative
- ☐ Other (state reason) _____

_____

_____

Please specify the health information you authorize to be released:

Type(s) of health information: _____

Date(s) of treatment: _____

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).
- ☐ Information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code §§5328, *et seq.*)
- ☐ Release of HIV/AIDS test results (Health and Safety Code §120980(g)).
- ☐ Release of genetic testing information (Health and Safety Code §124980(j)).

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires _____(insert applicable date or event). If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

_____ Print Name

_____ Signature (Patient, Parent)

_____ Date

_____ Relationship to Patient (Parent, Patient Rep)

_____ Date of Birth

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