Health, Housing &
Community Services Department

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization.

Name of patient: _____ Date of Birth: _____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize City of Berkeley Public Health Clinic to release to:

☐ Self/Client Phone:_____

PICK UP IN PERSON: ☐ YES	LOCATION: 830 UNIVERSITY AVE	TIME:
BY MAIL: (CLIENT ONLY) ☐ YES	CLIENT ADDRESS:	
BY FAX: (CLIENT ONLY) ☐ YES	FAX NUMBER:	

☐ Medical Office: _____ ☐ By Phone:_____

BY MAIL: ☐ YES	MEDICAL OFFICE ADDRESS:
BY FAX: ☐ YES	MEDICAL OFFICE FAX NUMBER:

The following information as indicated below:

Clinician's records/office visit write-ups: (check one or more)

☐ Include HIV test results/HIV status/other data ☐ Include STI/STD information ☐ Include family planning information ☐ Pap Smear results ☐ Colpo results ☐ Include only the following information: _____	☐ TB screening results ☐ Immunization ☐ Linkage to care & confirmation of attendance of 1st & 2nd appointments ☐ Other: _____ _____
For which dates do you want information:	
Date to begin search:	Date to end search:

PURPOSE OF DISCLOSURE _____

MY RIGHTS

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but I must do so in writing and submit it to City of Berkeley Public Health, 830 University Ave, Berkeley, CA 94710. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

I have a right to receive a copy of this authorization.

I recognize that if I am disclosing my health information to someone who is not legally required to keep it confidential, it may be disclosed and may no longer be protected. California law requires that recipients refrain from redisclosing such information except with my written authorization or as specifically required or permitted by law.

Information disclosed pursuant to this authorization may be subject to further disclosure by recipients not covered by federal HIPAA regulations. Although disclosed information may no longer be subject to federal privacy protections, state law requires recipients to refrain from re-disclosing such information unless another written authorization is obtained or specifically required by law.

EXPIRATION

This authorization expires on *(date)*: _____. If no expiration given, this authorization will expire 12 months from the signature date below.

SIGNATURE

Date: _____ Time:_____AM / PM

Signature: _____
(patient/legal representative)

If signed by other than patient, indicate relationship: _____

Print name: _____
(legal representative)

TO BE COMPLETED BY CITY STAFF	
TYPE OF PICTURE ID : (STAFF NEED TO VERIFY IDENTITY BY VIEWING A PICTURE ID): ☐ CA DRIVER'S LICENSE ☐ PASSPORT ☐ IMMIGRATION CARD ☐ OTHER PICTURE ID (SPECIFY): _____	STAFF INITIALS : *Revised: 3/15/16*