Carbon Health

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

PATIENT INFORMATION

Name: _____ Date of Birth: _____/_____/_____

E-mail: _____ Phone: _____

USE AND DISCLOSURE OF HEALTH INFORMATION

The below party may disclose health information (check one):

☒ Carbon Health

☐ Non-Carbon Provider/Organization: _____

Phone: _____ Fax/E-mail: _____

Information may be disclosed to the following recipient:

Name of Person/Organization: **UC College of the Law, San Francisco**

Phone: **(415) 565-4600** Fax: _____ E-mail: _____

200 McAllister Street	**San Francisco**	**CA**	**94102**
Street Address	City	State	Zip

Description of health information to be disclosed:

I authorize disclosure of the information described below (*check all that apply*):

Date(s) of Service/Time Period: _____

☐ Complete Records	☐ Provider Notes	☐ Care Plan
☐ Urgent Care Records	☐ Primary Care Records	☐ Labs
☐ Radiology (reports only)	☒ Immunization Records	☐ Medications
☐ History & physical	☐ Operative Reports	☐ Billing

☐ Other Records not listed above (please specify):_____

_____

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Check the boxes below if you want this release to include the following information. Otherwise, this information will be excluded.
☐ Mental Health Treatment Records ☐ HIV Test Results
☐ Drug/Alcohol Abuse Treatment Records

PURPOSE

The purpose of this use or disclosure is:

☐ Patient request ☐ Continuity of care ☐ Legal

☐ Insurance ☒ Other (please specify): _____

Compliance with UC Office of the President TB screening and vaccination requirements

RIGHTS

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may revoke this authorization by submitting a written, signed request to medicalrecords@carbonhealth.com. My revocation will take effect upon Carbon Health's receipt, except to the extent that Carbon Health or others have acted in reliance upon this Authorization.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and may no longer be protected by state or federal privacy law.

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

I understand that medical treatment may not be conditioned upon my signing of this authorization and that I may refuse to sign this authorization.

I have a right to receive a copy of this authorization. A copy of this authorization is as valid as the original.

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EXPIRATION

This authorization shall become effective immediately and expire one (1) year from the date of signing unless another date is specified below:

_____/_____/_____.
Expiration Date

SIGNATURE

Signature: _____ Date: _____/_____/_____
(Patient, Parent, Guardian, Representative)

If signed by someone other than the patient, please provide your printed name and legal relationship to the patient:

Printed Name: _____ Relationship: **Self**
(i.e. Parent, Guardian, Conservator)