



**CONSENTS/RELEASES • AUTHORIZATION FOR
DISCLOSURE OF HEALTH INFORMATION**

Please send request to:

Stanford Hospital and Clinics (SHC)
Medical Records - Rm HC029, MC 5200
300 Pasteur Drive, Stanford, CA 94305 - 5200
Phone: (650) 723-5721 Fax: (650) 725-9821

This authorization is for the use or disclosure of health information pertaining to:

Patient's Name: Last: _____ First _____ MI _____

DOB: _____ Phone Number: _____ MRN: _____

I hereby authorize: Stanford Hospital & Clinics, 300 Pasteur Drive, Stanford, CA 94305

(Other Healthcare Provider) _____
Name and address

To release health information to:

(Name of Person or Organization Receiving Information) Mailing Address City State Zip Code

Method of Release: Mail records/film/CD to the address above by regular mail

Pick-up at the Hospital I will visit the Hospital to inspect the records

Under certain circumstances, SHC may deny your request to inspect and/or copy your health information. If access is denied, you may request that the denial be reviewed. Instructions for the review process will be included with any denial.

This authorization applies to the following information:

- Medical Records (Specify): _____
- Radiology Film/CD (Request will be forwarded to the Film Library for processing. For questions, please call 650-723-6717)
- Billing Records (If requesting for SHC BILLING RECORDS ONLY, please mail directly to the SHC Billing Dept, File 74431, P.O. Box 60000, SF, CA 94160. For questions, please call 650-497-8123)
- Other Health Information (Specify): _____

A specific authorization is required to disclose information regarding the following:

(Check box and sign to specify information to be disclosed)

Signature

- Psychiatric/Mental Health _____
- Drug/Alcohol Abuse _____
- HIV Lab Test Result _____
- Genetic/Fertility _____

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PURPOSE: The recipient may use the health information authorized on this form solely for the following purpose (Specify):

EXPIRATION: This Authorization becomes effective immediately and shall expire on [date]:_____. (If no date is given, this authorization is valid for only six (6) months from the signature date)

MY RIGHTS

- I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits.
- The recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless the use or disclosure is specifically permitted by law. If further use or redisclosure by the recipient is permissible, the information may no longer be protected by the federal privacy law (HIPAA).
- I reserve the right to withdraw or revoke this authorization, in writing, at any time, except to the extent that SHC has already disclosed the information. I must submit my revocation to SHC HIMS Dept., 300 Pasteur Drive, Room H006, MC 5200, Stanford, CA 94305.
- I have a right to receive a copy of this authorization.

Signature: _____ Date: _____

Name of individual if signed by someone other than the patient:

Print

If signed by other than patient, indicate legal relationship:
