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

Stanford Hospital and Clinics

AUTHORIZATION - DISCLOSURE OF HEALTH INFORMATION

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:

_____ _____

(Name of Person or Organization Releasing Information) *Address* *City* *State* *Zip Code*

To disclose health information to:

_____ _____

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

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 _____

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

- I may refuse to sign and my refusal will not affect my ability to obtain treatment.
- 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.
- This authorization shall become effective immediately and shall remain in effect until _____ (If no date is given, authorization is valid for 6 months only from signature date).
- 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 understand that I have a right to receive a copy of this authorization.

Signature: _____ Date: _____

If signed by other than patient, indicate relationship: _____

Indicate preference: ❑ Mail records/film/CD to the address above ❑ Pick-up at the Hospital