AITC Immunization & Travel Clinic
101 Grove Street, Suite 102
San Francisco, CA 94102-4505
Tel. (415) 554-2625 | Fax (415) 554-2619
Email: Travelshots.dph@sfdph.org
www.TravelClinicSF.org

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: ____ Date of Birth: ________________________

Address: ____ Tel: (____)______________

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and federal law concerning the privacy of such information. I recognize that if I am disclosing my health information to someone who is not legally required to keep it confidential, it may be redisclosed 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 by law.

I HEREBY AUTHORIZE ☐ AITC
☐ Other ____
(Name of sending provider or facility)

TO RELEASE MY MEDICAL RECORDS TO:
☐ AITC
☐ Other ____ Tel: (____)_____________
(Name of receiving person, provider or facility)

____
(Address/City/state/ZIP of receiving person, provider or facility)

____ Fax: (____)______________
(Email of receiving person, provider or facility)

FOR THE PURPOSE OF: ☐ Consultation ☐ Transfer of Care ☐ Updating Records

☐ Other purpose *(please specify)*____

PLEASE RELEASE THE FOLLOWING RECORDS: ☐ Immunization Records ☐ TB test results

☐ Other records *(Please specify)*____

And TRANSMIT VIA: ☐ US Mail ☐ Fax ☐ Email ☐ by Hand ☐ Phone (verbal)

MY RIGHTS: I understand that authorizing the disclosure of this health information is voluntary. I may refuse to sign this authorization. I may revoke this authorization at any time. Revocation must be in writing, signed by me or on my behalf by someone with the legal authority to do so and delivered to the provider or facility. My revocation will be effective upon receipt but will not be effective to the extent that the provider or facility may have acted in reliance upon this authorization prior to revocation. I have a right to obtain a copy of this document. I may not be denied treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.
EXPIRATION: Unless revoked, this authorization will expire: ☐ in 90 days ☐ on *(date)* _________________

SIGNED: ____ ***DATE:*** _________________
(Signature of Patient or Legal Representative)

____ ☐ Interpreter used _________________
(Relationship, if signer is not the patient) *(Language)*

FOR INTERNAL OFFICE USE ONLY

☐ Request handled by ____ (staff) on ___________________ (date)
☐ Information released on ___________________ (date)
☐ Information not released

FORMAT OF REQUEST
☐ Written Request (ADHI completed & signed)
☐ Verbal Request
State why ADHI cannot be completed ____

____

FORMAT OF RELEASE
☐ Release in Writing
☐ Hand-to ☐ Fax ☐ US mail ☐ Email ☐ Other_____________________
☐ Verbal Release
☐ Phone ☐ Other_____________________

VERIFICATION OF CLIENT INFORMATION
☐ Name ___________________
☐ DOB ____________________
☐ Address __________________
☐ Phone ___________________
☐ Email ____________________
☐ Driver License Info ________ (state of issue) ___________________________(number)___________________(exp)
☐ Other Gov't ID Info ________ (place of issue) ___________________________(number)___________________(exp)

VERIFICATION OF OTHER REQUESTING PERSON INFORMATION
☐ Name ___________________
☐ DOB ____________________
☐ Address __________________
☐ Phone ___________________
☐ Email ____________________
☐ Driver License Info ________ (state of issue) ___________________________(number)___________________(exp)
☐ Other Gov't ID Info ________ (place of issue) ___________________________(number)___________________(exp)

Other Info: