



AITC Immunization & Travel Clinic  
 101 Grove Street, Suite 102  
 San Francisco, CA 94102-4505  
 Tel. (415) 554-2625 | Fax (415) 554-2619  
[www.TravelClinicSF.org](http://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

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(OK to write "see reverse" if sheets are not separated)

Staff Handling Request: \_\_\_\_\_ (name)  
Information released on \_\_\_\_\_ (date) OR  Information not released

FORMAT OF RELEASE (check all that apply)

N/A (Information not released)  
Release in Writing:  Hand-to  Fax  US mail  Email  Other \_\_\_\_\_  
Verbal Release:  Phone  Other \_\_\_\_\_

VERIFICATION OF CLIENT INFORMATION

- Name
- DOB
- Address
- Phone
- Email
- Signature
- Driver License Info
- Other Gov't ID Info

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)

Brief description of info to be released:

Instructions for staff:

Please review the AITC Policy and Procedure for PHI Release document every time a release is requested.  
After handling the release request:

Scan all items below and name the file: "ROI date of the request" then upload into client's electronic record:

1. One or both pages of a completed ADHI form, per instructions
2. Any written document released per this request
3. Email thread if applicable