UCSF Medical Center
Center for
Reproductive Health

Authorization for Disclosure of Protected Health Information to Partners

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California Law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosures below. Please review and complete this form carefully.

Signing this form allows UCSF Center for Reproductive Health to share your medical information with your partner.

1) I hereby authorize this medical practice to use and disclose health information Concerning :

Patient: _____ Date of Birth : _____
Print Name

Patient: _____ Date of Birth : _____
Print Name

2) Health information to be used or disclosed:

Any and all health information including but not limited to mental health records protected by the Lanterman-Petris Short Act, drug and/or alcohol abuse records, lab and/or HIV test results, itemized and payment history. If there is specific information you not want shared with your partner, please indicate below.

_____

3) This health information may be disclosed to:

Partner #1 or other : _____
Print Name Relationship to Patient Signature

Partner #2 or other : _____
Print Name Relationship to Patient Signature

This authorization is effective now and will remain in effect until further written notification from me. I understand that I have the right to receive a copy of this authorization.

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