UC San Diego Health

PATIENT NAME:

Patient Identification

MEDIA AND COMMUNITY RELATIONS AUTHORIZATION

I authorize UC San Diego Health to release my protected health information to (specify the name(s), or other identify of the person(s) or class or group of person(s), such as the media):

Street Address (If applicable): ______________________________

City, State, Zip Code (If Applicable): ____________, ________ ________

Phone Number (If Applicable): (______) ______________

AUTHORIZATION AND PURPOSE: I voluntarily give my permission for: (check one or both)

☑ Photographs, film or videotape of me to be taken and used by UC San Diego Health staff, the news media, or their representatives for the communication of events, programs, procedures at UC San Diego Health.

☑ Health information regarding my medical condition or treatment to be released to the news media, UC San Diego Health staff or their representatives for news stories or other public relations communications (TV, radio, newspapers, magazines, health web sites, or video news release). Please specify the health information you authorize for release:

☑ Type (s) of health information:
ANY AND ALL RELATING TO TRANSPLANT

☑ Date (s) of treatment:
ANY AND ALL RELATING TO TRANSPLANT

NOTICE: UC San Diego Health and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be subject to redisclosure and no longer be protected by state or federal confidentiality laws.

YOUR RIGHTS: This Authorization to release health information is voluntary. You are not required to sign this authorization in order to receive treatment, for payment of your care, or for enrollment in a health plan or eligibility for benefits.

The following information will not be released unless you specifically authorize it by initialing the relevant line(s) below:

_____ I specifically authorize the release of information pertaining to drug and alcohol abuse, diagnosis or treatment (42 C.F.R. §§2.34 and 2.35).

_____ I specifically authorize the release of information pertaining to mental health diagnosis or treatment (Welfare & Institutions Code §§ 5328, et seq.)

_____ I specifically authorize the release of HIV/AIDS test results (Health and Safety Code §120980(g)).

_____ I specifically authorize the release of genetic testing information (Health and Safety Code §124980(j)).

(OVER)

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This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to: **LIFESHARING**
The revocation will take effect when UC San Diego Health receives it, except to the extent UC San Diego Health or others have already relied on it. You are entitled to receive a copy of this Authorization.

Print Name ______ Signature (Patient, Parent, Guardian) ______ Date ______ Time ______

Relationship to Patient (Parent, Guardian,Conservator, Patient Representative) ______

Witness (if patient unable to sign) or Interpreter ______

Phone Number (______) ______

Mailing Address: ______

Send original copy of this form to Health Sciences Communications MC 8907.
Give copy of this form to the patient.