UCSD Care Program
140 Arbor Drive, 4th Floor
San Diego, CA 92103
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AUTHORIZATION TO RELEASE PATIENT RECORDS

FEDERAL LAW REQUIRES YOUR SPECIFIC AUTHORIZATION FOR US TO RELEASE TO APPROPRIATE PARTIES ANY INFORMATION ABOUT YOUR TREATMENT FOR CERTAIN CONDITIONS. PLEASE CHECK ALL PERTINENT SECTIONS BELOW.

I authorize _____to disclose to and/or receive from/to Kristin Cadenhead, M.D. and associates at UCSD medical records or information relating to my diagnosis and/or treatment for (check all pertinent items):

_____ Physical injuries, illnesses or conditions
_____ History and Physical Exam
_____ Laboratory Data/ X-ray Reports
_____ Alcohol abuse and/or drug abuse

_____ Mental (psychological or psychiatric) illness or conditions
_____ Psychological Testing
_____ Psychiatric Evaluation
_____ Verbal Communication

_____ Family counseling
(Note: Multiple records may not be released without obtaining signed consent from all parties who participated in the counseling sessions.

_____ Discharge Summary
_____ Discharge Instructions
_____ Medication Records
_____ Individual Education Plans (IEP)
_____ Verbal Communication

For the following date(s) of treatment: _____ to _____

This information is required for evaluation and treatment

I may revoke this authorization at any time before the information has been released. In any case, the authorization automatically expires on: ____/_____/_____

Patient (print name) _____ Date of Birth _____

Patient's Signature _____ Date _____

Guardian/Conservator (if applicable) _____ **Signature of Provider authorization** _____

Specifically Protected Information

I understand that a variety of tests have been undertaken and one of them may have been an HIV-related test. My signature below authorizes release of any test results, including any HIV-related (AIDS) test results

_____ _____
Your authorization (patient or legal guardian) Date of Birth

REFERRAL REQUEST

Reason for referral: _____

_____

In cases of referral, please have patient/client sign if they would like to grant permission for UCSD Care to contact them directly:

Patient's Signature_____ Date _____

Home Phone: _____ Cell Phone: _____

Insurance Provider: ☐ **None** ☐ **Medi-Cal** ☐ **Private**