UCSF Benioff Children's Hospital Oakland

DIVISION OF MENTAL HEALTH & CHILD DEVELOPMENT

RELEASE OF INFORMATION/ CONSENT FOR REFERRAL

747 52nd St., Oakland, CA 94609 • 510-428-8428 • www.childrenshospitaloakland.org

THIS RELEASE/CONSENT IS REQUIRED FOR THE REFERRAL TO BE PROCESSED.

I HEREBY AUTHORIZE THE USE AND/OR DISCLOSURE OF MY HEALTH AND MENTAL HEALTH INFORMATION TO:

UCSF Benioff Children's Hospital Oakland
Mental Health & Child Development Services
747 52nd Street
Oakland, CA 94609

PATIENT INFORMATION

Patient's Name_____Date of birth _____

Social Security #_____

PERSON/ORGANIZATION RELEASING THE PATIENT'S HEALTH AND/OR MENTAL HEALTH INFORMATION

Name/Organization _____

Street Address _____

City_____State_____Zip _____

PARENT/GUARDIAN/CAREGIVER AUTHORIZATION

Name of patient's legal representative (parent or guardian) _____

Signature _____

Phone_____Date_____

Name of patient's personal representative (if applicable) _____

Relationship to patient _____

Signature _____

Phone_____Date_____

I have the right to a copy of this authorization. Copy requested: ☐ No ☐ Yes

This authorization shall be valid for one (1) year from the date above.