University of Student Health Center California, Irvine

501 Student Health
Irvine, CA 92697-5200
(949) 824-5302
FAX: (949) 824-3033

Authorization for Release of Health Information

PLEASE PRINT:

____

Patient Name (Last, First MI) Birthdate UCI Student ID No.

____

Address City State Zip Code Telephone No.

AUTHORIZATION: I hereby authorize UCI Student Health Center:
- ❑ To release information to:
- ❑ To exchange information with:
- ❑ To request information from:

(Specify name/title of person to receive information, if known)
Name:
Address:
Phone:
Fax:

TYPE OF DISCLOSURE: ❒ Copies of records ❒ Verbal information
❒ Other (e.g. Summary, Report, Letter): ____________________

Please specify the health information you authorize to be released:

- ❒ All Medical Records (This may include drug/alcohol and mental health information documented by a primary care practitioner)
- ❒ Gynecology Records
- ❒ Lab/Path Report(s): ______________
- ❒ X-Ray Report(s): _______________
- ❒ X-Ray Film(s): _________________
- ❒ Immunization Records and/or TB Test Results
- ❒ Mental Health Information (Subject to the Lanterman-Petris-Short Act, Welf & Inst. Code §5000 et seq.) – *Please also check **Specific Authorizations** on page 2.*
- ❒ Other (specify): ____

SPECIFIC AUTHORIZATIONS

The following information will not be released unless you specifically authorize it by checking and initialing the relevant box(es) below:

Initials:

- ❑ _____ 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 and Institutions Code §5328, *et seq.*).
- ❑ _____ I specifically authorize the release of HIV/AIDS testing information (Health and Safety Code §120980(g)).

PURPOSE OF RELEASE: The requester may use the medical records and other information so authorized for the following purposes:

____

____

NOTICE:

The UCI Student Health Center 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 no longer be protected by state or federal confidentiality laws.

MY RIGHTS:

- I understand this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) obtaining information in connection with eligibility or enrollment in a health plan, 3) determining an entity's obligation to pay a claim, or 4) creating health information to provide to a third party. Under no circumstances, however, am I required to authorize the release of mental health records.
- I may revoke this authorization at any time, provided that I do so in writing and submit it to UCI Student Health Center, 501 Student Health, University of California, Irvine, Irvine, CA 92697-5200. The revocation will take effect when UCISH receives it, except to the extent that UCISH or others have already relied on it.
- I am entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION: Unless otherwise revoked, this authorization is effective immediately and shall remain in effect until ________________________.
(If no date is indicated, this Authorization will expire 12 months after the date of my signing this form.)

A copy of this authorization shall be valid as an original.

Signed: ____ Date: ________________
(*Signature of Patient or Legal Representative*)

Printed Name: ____

Relationship to Patient if Signed by Other than Patient:

____

For SHC MHC Use Only

Request noted by MHC Provider:__________
Initials

Med Rec No.: _________________________

❒ Mailed ❒ Faxed ❒ Hand Carried by Pt.

Date Completed: ______________________

Initials: ______________

For SHC Medical Record Dept. Use Only

Med Rec No.: _________________________

❒ Mailed ❒ Faxed ❒ Hand Carried by Pt.

Date Completed: ______________________

Initials: ______________