University of California, Riverside
Student Health Services

Patient Portal Release of Information
Standard Operating Procedure

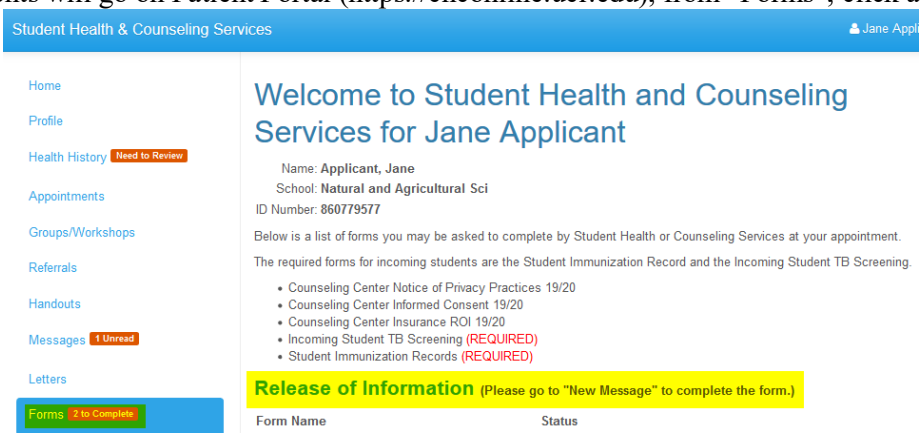
Responsible Manager	Senior Administrative Director
Creation date	10/08/2020

Introduction:
Active students with access to their Patient Portal will be asked to request Medical and/or Billing Records for release or exchange through their personal Patient Portal. This was implemented for their security, compliance, ease of submission and internal tracking within PnC. All other requests may continue to use prior established methods of requesting records.

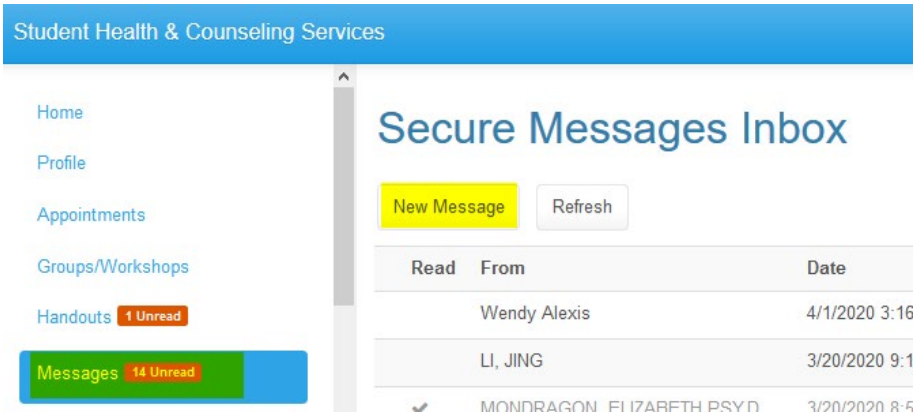
STUDENT INSTRUCTIONS
VIEW FROM THEIR PATIENT PORTAL

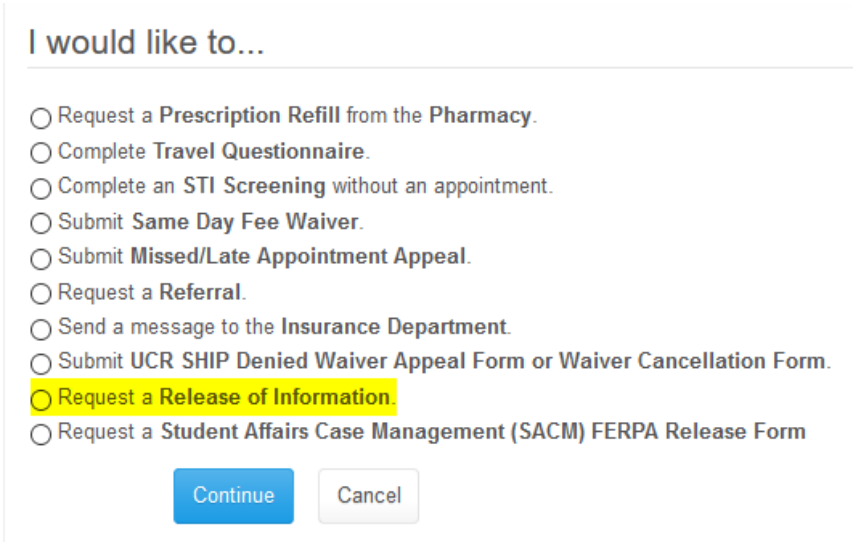
Procedure:

1: Students will go on Patient Portal (https://chconline.ucr.edu), from "Forms", click a link to go to "Messages" page.

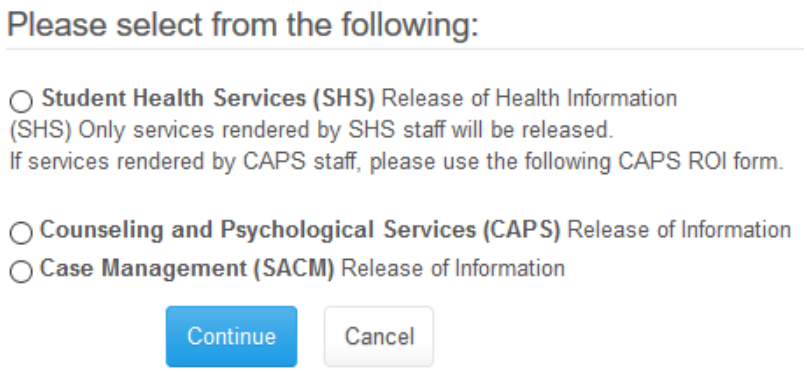


Or from "Message" page, students can click the "New Message" button, then chose the option "Request a Release of Information".





2. On the next page, students can choose which Release of Information they need.



When the student chooses SHS ROI:

1. They will fill out the ROI information and can compose a new secure message and it will be sent to "SHS, MEDICAL RECORDS" provider.
2. The ROI will be available in the chart messages and create a "task" for the SHS MEDICAL RECORDS provider and
    a. Be visible to the student in PNC so they can track the progress of their request.
    b. Student can send secure messages directly to medical records staff concerning their request.
3. Medical Records staff are assigned to the SHS MEDICAL RECORDS provider to receive the incoming medical records task notifications to complete.

Compose New Secure Message

Recipient: SHS, MEDICAL RECORDS
Message Type: SHS Realease of Information
Subject: Request for Release of Health Information
Attachments: Add attachment...

Items marked with **are required.

University of California Riverside

Student Health Services (SHS)
900 University Avenue
Veitch Student Center
Riverside, CA 92521
(951) 827-3031 Telephone
(951) 827-3133 Fax

Authorization for Release and Exchange of Health Information

Please fully complete this form. Student Health Services does not charge for the release of medical records to physician offices for the purpose of treatment. However, a fee will apply to records released to non-medical entities (self or family).

Patient Information

** Last Name
** First Name
Initial
** Address
** City
** State
** Zip
** Phone
** Student ID No.
** Date of Birth

Authorization

Patient hereby authorizes UCR Student Health Services to:

☐ Release information to:

☐ Exchange information with:

☐ Self at the address listed above

** Name
** Address
** City
** State
** Zip Code
** Phone
Fax
Email

Type of disclosure

☐ Verbal communication

☐ Copies of Records

Health Information Authorized to be Released

Specify date(s) of treatment or time period. (Note: Unless otherwise specified, only the last 2 years of records are released.)

From Date

End Date

Choose the following options:

☐ ALL MEDICAL RECORDS (May include drug/alcohol and mental health information documented by primary care practitioner.)

☐ Mental health information (subject to the Lanterman-Petris-Short Act, CA Welf. & Inst. Code 5000 § et seq.) (SHS services, not related to CAPS services.)

☐ Billing records

Specify date(s) of treatment or time period. (Note: Unless otherwise specified, only the last 2 years of records are released.)

Please also check the appropriate Specific Authorizations below.

☐ Gynecology Records

☐ Immunization Records

☐ TB Test Results

☐ Lab/Path Report(s) (specify in the box below):

☐ X-Ray Report(s) (specify in the box below):

☐ X-Ray Image(s) (specify in the box below):

☐ Other (specify in the box below):

Please specify which report(s) are being requested.

Specific Authorizations

The following information will not be released unless you specifically authorize it by checking the relevant box(es) 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. (Cal. Welf & Inst. Code § 5328 et seq.).

☐ I specifically authorize the release of HIV/AIDS testing information. (Cal. Health & Safety Code §120980(g).)

Purpose of Release

☐ Continuity of care

☐ Insurance purpose

☐ Legal mater

☐ Personal use

Other purposes:

NOTICE

UC Riverside Student Health Services (and many other organizations such and individuals such as physicians, hospitals, and health plans) is 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.

Patient Rights

This Authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except when 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 circumstance is the patient required to authorize the release of mental health records.

The requestor may revoke this Authorization at any time. To do so, the requestor must revoke this Authorization in writing and submit the revocation to UCR Student Health Services, 900 University Avenue, Veitch Student Center, Riverside, CA 92521. The revocation will take effect when UCR Student Health Services receives it, except to the extent that UCR Student Health Services or others have already relied on it.

Patient is entitled to a copy of this Authorization upon request.

Expiration and Validity of Authorization

Unless otherwise revoked, the Authorization is effective immediately and shall remain in effect until

If no date is indicated, this Authorization will expire twelve (12) months after the date of requestor's submission of this form.
A copy of this Authorization shall be valid as an original.

By sending this message, I hereby consent to the release of information as outlined above and acknowledge that I have read and agree with the information provided above.

Please press the "Send" button below when you have completed the form and sent the message. If you have forgotten to complete any required fields, an information box will be displayed at the top of the form and you will need to scroll down the page to find and complete the missing information.

Send Cancel

END OF STUDENT PORTAL VIEW