UC RIVERSIDE | Student Health Services

UCR Student Health Services
900 University Avenue MC86
Riverside, CA 92521
(951) 827-3031 Telephone
(833)260-8603 Medical Records Fax
Email: shsmedrecords@ucr.edu

Authorization for Release, Request or Exchange of Health Information

Please complete, sign and date this form. Student Health Services does not charge for the release of medical records to physician offices for the purpose of treatment. Fees may apply to records released to non-medical entities including self or family. Please see our fee schedule and additional information located on our website at https://studenthealth.ucr.edu/

Patient Information:

Last Name:_____ First Name:_____ Middle Initial:___

Address: _____ City:_____ State:_____ Zip:_____

Phone:_____ Student ID No.:_____ Date of Birth:_____

Authorization:

Patient hereby authorizes UCR Student Health Services to : ☐ **Release** ☐ **Request** ☐ **Exchange** information:

Name:_____ Phone:_____

Address:_____ Fax:_____

City:_____ State:_____ Zip:_____ Email:_____

Purpose of Release:

☐ Continuity of Care ☐ Disability ☐ Insurance ☐ Legal ☐ Self

☐ Other (Please Specify):_____

Health Information to be released:

For Dates of Service _____ to _____ (if no date range is indicated one year of most current records will be released).

☐ Clinic Visit (office notes, procedure notes, lab, diagnostic, and radiology results)

☐ Mental health information (subject to the Lanterman-Petris-Short Act, CA Welf. & Inst. Code 5000 § et seq.)

Please also check the appropriate Specific Authorizations below. Services provided by SHS behavioral staff only. CAPS will not be included.

☐ Immunizations records

☐ Gynecological records

☐ Medical insurance billing records

☐ TB Test Results:

☐ Lab/Path Report(s):

☐ X-Ray Report(s):

☐ X-Ray Image(s):

☐ Other:

Please specify which report(s) you are requesting:

Specific Authorizations: The following information will not be released unless you specifically authorize it by initialing 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).*

Requested method of delivery: ☐ Fax ☐ Email ☐ Mail ☐ Pick up

NOTICE:

UC Riverside Student Health Services (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.

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 requester may revoke this authorization at any time. To do so, the requester must revoke this authorization in writing and submit the revocation to UCR Student Health Services, 900 University Avenue MC86, 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, this 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 signature.

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

_____ _____

Signature of patient or patient's legal representative Date

_____

Printed name of signatory

_____

Relationship to patient (if signed by other than patient)

For Student Health Services Only: Staff name completing : Date completed:

Requested Records ☐ Released Records ☐ ☐ Faxed ☐ Emailed ☐ Mailed ☐ Placed for pick up ☐ Handed to patient

Records not released ☐ Reason: