UC RIVERSIDE UNIVERSITY OF CALIFORNIA | Student Health Services

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

AUTHORIZATION FOR RELEASE OF FINANCIAL INFORMATION

THIS AUTHORIZATION IS FOR THE RELEASE OF FINANCIAL AND INSURANCE RELATED INFORMATION ONLY. RELEASE OF MEDICAL RECORDS REQUIRES COMPLETION OF A SEPARATE AUTHORIZATION.

Patient Information

Last Name _____ First Name _____ Initial ____

Address _____ City _____ State ____ Zip _____

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

Authorization

Patient hereby authorizes the staff of UC Riverside Student Health Services to release financial information regarding Patient's Student Health Insurance, waiver, and medical claims, to:

Name _____ Phone _____

Address _____ Fax _____

City _____ State ____ Zip Code _____

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 financial records.

The requestor may revoke this Authorization at any time. To do so, the requestor must 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, 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 requestor's signature at the bottom of this form. 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)

Print Form

Form Revised: 8/1/13