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 HEALTH INFORMATION

Please fully complete, print, and sign 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 ____________________
(select authorization)

Name ____________________ Phone ____________________

Address ____________________ Fax ____________________

City ____________________ State ____ Zip Code ____________________

Type of Disclosure:

Indicate other:

Health Information Authorized to be Released

- ☐ 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.)
  Please also check the appropriate Specific Authorizations below.
- ☐ Gynecology Records
- ☐ Immunization Records
- ☐ TB Test Results

- ☐ Lab/Path Report(s) *(specify)*:
- ☐ X-Ray Report(s) *(specify)*:
- ☐ X-Ray Image(s) *(specify)*:
- ☐ Other *(specify)*:

Please specify which report(s) are being requested.

Specific Authorizations

The following information will not be released unless you specifically authorize it by checking and 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).

Purpose of Release

The requestor may use the medical records and other information so authorized for the following 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 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)

For Medical Record Office Use Only

☐ mailed ☐ faxed ☐ hand carried by pt.

Date Completed: ________________ Initials: ________

Form Revised: 8/1/13