

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I HEREBY AUTHORIZE: (name of person or facility which has information)

Name/facility _____

Address _____

Phone _____

Fax _____

TO RELEASE TO: (name of person or facility to receive information)

Name/facility _____

Address _____

Phone _____

Fax _____

Patient Name _____ Student ID# _____ Date of Birth _____

Address _____ Phone _____

CHECK ALL BOXES THAT APPLY

Type of Disclosure: Copies of Records Verbal Information/Communication

Other specify: _____

Please specify the health information you authorize to be released:

Lab/Pathology Results X-Ray Film(s) Immunizations/vaccinations TB Test STD Results
 All Medical Records (x-rays, labs, immunizations) EAP iPledge Billing/Insurance

Other specify: _____

Specific date(s) of treatment: _____

Purpose: Personal Records Continuity of care Billing/Insurance Referral iPledge

Other specify: _____

The following information will not be released unless authorized by marking the relevant box below:

I specifically authorize the release of HIV/AIDS test results (Health & Safety Code §120980(g)).

I specifically authorize the release of genetic testing information (Health & Safety Code §124980(j)).



NOTICE

UC Santa Cruz 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.

YOUR RIGHTS

This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to: Medical Records Department (UC Santa Cruz Student Health Services, 1156 High Street, Santa Cruz, CA 95064). The revocation will take effect when UC Santa Cruz Student Health Services receives it, except to the extent UC Santa Cruz Student Health Services or others have already relied on it. You are entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires _____ (insert applicable date or event). If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

Print Name

Signature (Patient, Parent, Guardian)

Date Time

Relationship to Patient (If Applicable)

Witness (only if patient unable to sign) or interpreter

For UC Santa Cruz Student Health Center Use (check applicable):

Records Requested:

- Mailed to address on page 1
 - Faxed to number on page 1
- Initials: _____ Date: _____

Records Released:

- Mailed to address on page 1
 - Faxed to number on page 1
 - Handed to patient
 - Left in patient pickup box
- Initials: _____ Date: _____ # of pages: _____

Request for Verbal Information Only:

- Note entered in PnC
- Initials: _____ Date: _____

Records not Released:

- Patient never picked
 - No Release made
- Reason: _____
- Initials: _____ Date: _____

