UCSC Student Health Services (SHS)
1156 High St
Santa Cruz, CA 95064

Medical Records Department
Tel: (831) 459-3063
Main FAX: (831) 459-3546 CAPS FAX (831) 459-5116

AUTHORIZATION FOR RELEASE OF MENTAL AND/OR MEDICAL HEALTH INFORMATION

Complete All Fields in Black Ink **Check All Applicable Boxes**

Name: _____Student ID#: _____ Date of Birth:_____/_____/_____

Address: _____City: _____State: ____ Zip: _____ Phone: _____

KAISER MRN if applicable:_____

AUTHORIZATION—Patient hereby authorizes Student Health Services to:

☐ Release Information to: ☐ Request Information from: ☐ Mutually exchange information with:

Name or Facility*:_____ **Title or Relationship**_____

Street Address:_____ **Phone:**_____ **Fax:** _____

City _____ **State** _____ **Zip:**_____

OR ☐ College—Academic: _____
☐ College—Res Life:_____
☐ Slug Support Network

***REMINDER: KAISER requires MRN:** _____

Type of Disclosure (check all boxes that apply):

1. ☐ **Verbal Information/Communications**
2. ☐ **Copies of Records / Written Information:**
   - ☐ Complete Record ☐ Most Recent Visit Only
   - ☐ Immunizations ☐ TB Test ☐ Summary Letter (CAPS only) ☐ Billing & Insurance
   - ☐ Other-Please Specify:_____

Please specify the information you authorize to be released:

Specify date(s) of treatment or time period (Unless otherwise specified, the last two years of records are requested): _____

☐ **Medical** (This may include drug, alcohol and mental health information documented by a SHC primary care practitioner).

☐ **Mental health information** (Subject to the CMIA Act).

☐ **HIV/AIDS test results—Cannot be released unless checked** (Health and Safety Code § 120980 (g))

☐ **Other information**, or limitations, if not specified above: _____

_____

Purpose of this release is:

☐ Continuity of Care
☐ At the request of the client/patient/patient representative
☐ Other (state reason): _____

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NOTICE:

University of California, Santa Cruz—SHS (SHC, CAPS or Psychiatry) 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 (i.e. Academic Advisor, Residential Staff, Faculty etc.), it may no longer be protected by state or federal confidentiality laws or FERPA Guidelines.

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) solely 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 client/patient representative, and delivered to: **UC Santa Cruz Student Health Services, Medical Records**
1156 High Street, Santa Cruz, CA 95064

The revocation will take effect when UCSC Student Health Services receives it, *except* to the extent UCSC Student Health Services or others have already relied on it. You are entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION: *This Authorization is good for one year from date signed*, unless otherwise specified under Expiration of Authorization.

Expiration of Authorization—This Authorization expires on _____

_____	_____	_____
Print Name	**Signature (Patient, Parent, Guardian)**	**Student ID#**

_____	_____	_____
TODAY's DATE MM/DD/YY	**Relationship to Patient (If Applicable)**	**Witness (only if patient unable to sign) or interpreter**

For UC Santa Cruz SHC Medical Records Department Use Only (check applicable):

Records Request:
☐ Mailed to address on page 1 Date mailed:_____
☐ Faxed to number on page 1 Time Faxed: _____
Initials: _____ Date: _____

Request for Verbal Information Only:
☐ Note entered in PnC
Initials: _____ Date: _____

Records Released:
☐ Mailed to address on page 1 Date mailed: _____
☐ Faxed to number on page 1 Time Faxed: _____
☐ Handed to patient
☐ Left in patient pickup box
☐ Electronically
Initials: _____ Date: _____

Records Obtained from SC Health Exchange:
Initials: _____ Date: _____

Records not Released:
Reason: _____
Initials: _____ Date: _____