UNIVERSITY OF CALIFORNIA, SANTA CRUZ
1156 High Street. SANTA CRUZ, CA 95064

STUDENT HEALTH CENTER MEDICAL RECORDS
TEL: (831) 459-3063 FAX: (831) 459-3546

Authorization for Release of Health Information

Please Complete All Fields in Black Ink

Patient Name:_____ Student ID#:_____ Date of Birth: _____

Address:_____ Phone: _____

Street City State Zip

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:_____

CHECK ALL BOXES THAT APPLY

Type of Disclosure: ☐ Copies of Records ☐ Verbal Information/Communication

Please specify the health information you authorize to be released:
☐ **ALL Medical Records**

OR Specific Records (check appropriate box):
☐ Billing/Insurance ☐ Lab/Pathology Results ☐ X-Ray ☐ Immunizations/vaccinations
☐ TB Test ☐ STD Results ☐ Other Please specify_____

Specific date(s) of treatment if applicable: _____

Purpose: ☐ Personal Records ☐ Continuity of care ☐ Billing/Insurance

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)).

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NOTICE

UC Santa Cruz Student Heath 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 Center, 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.**

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)_____ Time _____

Relationship to Patient (If Applicable): _____

Witness (only if patient unable to sign) or interpreter: _____

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

Records Request:
☐ Mailed to address on page 1 Date mailed_____
☐ Faxed to number on page 1 Time Faxed _____
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
Initials:_____Date:_____# of pages: _____

Request for Verbal Information Only:
Initials:_____Date: _____

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

Records not Released:
Reason: _____
Initials:_____Date: _____