UC Irvine
Student Health Center

For staff use -
Date of birth:
Student ID:
Patient Name:
(patient label)

PATIENT AUTHORIZATON TO RELEASE OF MENTAL HEALTH INFORMATION

To submit your medical records request, please complete all pages of this form.
501 Student Health, Irvine, CA 92697-5200 P: (949) 824-2021 F: (949) 824-3033
E-mail: shc-medical-records@uci.edu
Any fields scribbled, illegible or crossed-out will not be accepted

SECTION 1 – Patient information:

Patient Name: _____ Student ID #: _____

Other names used: _____

Mailing Address: _____

City, State & Zip Code: _____

Date of Birth: _____ Phone Number: _____

Email or UCI Net ID: _____

SECTION 2 – Release or request of medical information and/or record: Check one or more of the following.

I authorize UC Irvine, Student Health Center to:

☐ Release record to ☐ Request record from

☐ Mutually exchange verbal information with

SECTION 3 – Name or facility to request or release record(s): (*Each of the following fields **must be** filled-in to avoid any delay of request. An incomplete form may not be processed.*)

Name of person (and relation to patient) or facility: _____

Street Address: _____

City, State & Zip Code: _____

Phone Number: _____ Fax Number: _____

E-mail: _____

**Please note that requests are processed within 15 days of the date this form is received.*

SECTION 4 – Date of Upcoming Appointment:

If you need your record(s) for an upcoming appointment at the Student Health Center, please note your appointment date/time: _____

SECTION 5 – HEALTH INFORMATION TO BE RELEASED OR REQUESTED: Check each item that applies to the record(s) being released or requested.

☐ Immunizations & titer results ☐ Lab results

☐ Radiology results ☐ STI test results

☐ Medical notes *(this may include eating disorder, drug/alcohol, and mental health information by a primary care practitioner.)*

☐ Gynecology notes ☐ Itemized billing

☐ Billing statement ☐ Other: _____

SECTION 6 – SENSITIVE INFORMATION TO BE RELEASED OR REQUESTED: Initial next to each item that applies to the record(s) being released or requested. By initialing, you acknowledge that we are requesting or releasing sensitive medical information.

_____ *(please initial)* Drug & alcohol abuse, diagnosis, or treatment information, subject to Federal law.

_____ *(please initial)* Mental Health Services *(subject to review by licensed professional before disclosure.)*

_____ *(please initial)* HIV/AIDS test result

_____ *(please initial)* Genetic test result

_____ *(please initial)* Abortion or abortion related services

SECTION 7 – EXCLUSION FOR RELEASE: Any data or detail not allowed to be shared or disclosed should be noted below.

If not applicable, write N/A: _____

SECTION 8 – DATE OF TREATMENT, TIME PERIOD OR CONDITION: Specify date(s) of treatment received. If no date is indicated, only the last 2 years of records will be released.

Date(s): _____

SECTION 9 – PURPOSE OF THE RELEASE OF INFORMATION: Initial and/or check each box that applies.

_____ *(please initial)* At the request of the patient/patient representative.

_____ ☐ Case management or continuation of care.

_____ ☐ Other *(state reason):* _____

SECTION 10 – EXPIRATION OF AUTHORIZATION:

Unless otherwise revoked in writing, this authorization expires after **duration of care**.

If no date is indicated, the authorization will expire 12 months after the date of signing this form or 10 years for Mental Health records.

SECTION 11 – FEES FOR AUTHORIZATION: There is NO FEE for medical records sent directly to another facility or clinic.

_____ *(please initial)* I understand that I may be charged a per page fee for copies. *(Refer to Medical Records and Health Information page for fees on the SHC website.)*

SECTION 12 – DELIVERY METHOD OF RECORD: Indicate preferred delivery method of record(s).

_____ ☐ E-fax

_____ ☐ Encrypted E-mail

_____ ☐ Hand carried by patient

_____ ☐ Secured message in portal

_____ ☐ USB

_____ **(*please initial)* **I understand that, if chosen, delivery via E-fax and encrypted E-mail carries security risks.**

SECTION 13 – SIGN AND DATE:

Complete, sign and date this form. In order to verify your identification and validate your authorization, you are asked to include a legible copy of a valid Government issued photo identification, along with this completed/signed form. (i.e., passport, state issued ID/driver's license, or military ID.)

Print name: _____ Date: _____

Signature: _____
(Signature of Patient or Patient's Legal Representative)

Relation to Patient: _____
(If other than patient or in the event of a minor patient)

You are entitled to receive a copy of this Authorization.

NOTICE: UC Irvine 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.

This authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to: UC Irvine, Student Health Center, 501 Student Health, Irvine, CA 92697-5200, Attn: Health Information Management Services. The revocation will take effect when UC Irvine receives it, except to the extent UC Irvine or others have already relied on it.

Your RIGHTS: This authorization to release health information is voluntary. I understand I do not have to sign this authorization in order to get health benefits (treatment, payment or enrollment). However, I do have to sign this authorization form 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 information will not be used for any purpose other than its intended use.

A person or entity requesting the information will destroy the information and all copies in the person's or entity's possession or control, will cause it to be destroyed, or will return the information and all copies of it before or immediately after the length of time has expired.

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