UCI Student Health Center

Date of Birth:
Student ID:
Patient Name:
(Patient Label)

PATIENT AUTHORIZATION TO RELEASE 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

Patient Information	Patient Name: Student ID #: Street Address: City, State & Zip Code: Phone number: Email Address:
Release or Request of medical information and/or record. (Each field must be filled in to avoid any delay of request. An incomplete form may not be processed)	**I authorize UCI Student Health Center to:** ☐ Release record to ☐ Request record from ☐ Mutually exchange verbal information with Name/Facility: Street Address: City, State & Zip Code: Phone #: Fax #: E-mail: **Please note that requests are processed within 15 days of the date this form is received.**
Date of appointment	If you need your record(s) for an appointment on a specific date, please note it here. Date:
Health information to be released or requested (Check each box that applies)	☐ **Immunizations & titer results** ☐ **Lab results** ☐ **Radiology records** ☐ **Medical notes** (this may include eating disorder, drug/alcohol, and mental health information by a primary care practitioner) ☐ **Gynecology notes** ☐ **STI test results** ☐ **Itemized billing** ☐ **Billing statement** ☐ **Other:**

Sensitive Information to be released or requested. (**INITIAL** next to each item that applies)	**Drug and alcohol abuse, diagnosis, or treatment information subject to federal law.** **Mental Health Services** (subject to review by licensed professional before disclosure) **HIV/AIDS test results** **Genetic testing results** **Abortion or abortion related services**
Date(s) of treatment, time period or condition.	(If no date is specified, only the last 2 years of records will be released) Date(s): Duration of treatment
Exclusion of Release:	(If not applicable, write NA)
The purpose of this release	(initial) At the request of the patient/patient representative. ☐ Case Management/Continuation of care ☐ Other (state reason):
Expiration of Authorization	Unless otherwise revoked, this authorization expires If no date is indicated, the authorization will expire 12 months after the date of my signing this form or 10 years for Mental Health records.
Fees	NO FEE for medical records sent directly to another facility or clinic. Records for personal use: (initial)I understand I may be charged a per page fee for copies. (Refer to Medical Records and Health Information page for fees on the SHC website)
Indicate preferred delivery method of record(s).	☐ FAX ☐ SECURE MESSAGE ☐ E-MAIL ☐ USB ☐ MAIL ☐ HAND CARRIED BY PATIENT

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

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

Print Name

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

Relations to Patient (if other than Patient):

Date

You are entitled to receive a copy of this Authorization.

NOTICE: UCI 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: UCI Student Health, 501 Student Health, Irvine, CA 92697-5200, Attn: Health Information Management Services. The revocation will take effect when UCI receives it, except to the extent UCI 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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