UNIVERSITY of CALIFORNIA • IRVINE

Authorization for Release of Health Information

Student Health Center
501 Student Health
Irvine, CA 92697-5200
949-824-5302
Fax 949-824-3033

Patient Information

Last Name _____ First Name _____ Initial ____

Address _____ City _____ State ____ Zip _____

Phone _____ Student ID No.: _____ Date of Birth: _____

Authorization

Patient hereby authorizes UCI Student Health Center to _____
(select authorization)

Name _____ Phone _____

Address _____ Fax _____

City _____ State ____ Zip Code _____

Type of Disclosure: _____ Indicate other: _____

Health Information Authorized to be Released

- ☐ ALL MEDICAL RECORDS (May include drug/alcohol and mental health information documented by primary care practitioner.)
- ☐ Mental health information (subject to the Lanterman-Petris-Short Act, CA Welf. & Inst. Code 5000 § et seq.)

Please also check the appropriate Specific Authorizations below.

- ☐ Gynecology Records
- ☐ Immunization Records
- ☐ TB Test Results

- ☐ Lab/Path Report(s) *(specify)*:
- ☐ X-Ray Report(s) *(specify)*:
- ☐ X-Ray Film(s) *(specify)*:
- ☐ Other *(specify)*:

Please specify which report(s) are being requested.

Specific Authorizations

The following information will not be released unless you specifically authorize it by checking and initialing the relevant box(es) below.

☐ _____ I specifically authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment.
42 C.F.R. §§ 2.34 and 2.35.

☐ _____ I specifically authorize the release of information pertaining to mental health diagnosis or treatment.
Cal. Welf & Inst. Code § 5328 et seq.

☐ _____ I specifically authorize the release of HIV/AIDS testing information.
Cal. Health & Safety Code § 120980(g).

Purpose of Release

The requestor may use the medical records and other information so authorized for the following purposes:

NOTICE:

The UCI Student Health Center (and many other organizations such and individuals such as physicians, hospitals, and health plans) is 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.

Patient Rights

This Authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except when the authorization is for 1) conducting research related treatment, 2) obtaining information in connection with eligibility or enrollment in a health plan, 3) determining an entity's obligation to pay a claim, or 4) creating health information to provide to a third party.

Under no circumstance is the patient required to authorize the release of mental health records.

The requestor may revoke this Authorization at any time. To do so, the requestor must must revoke this Authorization in writing and submit the revocation to the UCI Student Health Center, 501 Student Health, Irvine, CA 92697-5200. The revocation will take effect when UCI Student Health Center receives it, except to the extent that UCI Student Health Center or other have already relied on it.

Patient is entitled to a copy of this Authorization.

Expiration and Validity of Authorization

Unless otherwise revoked, this Authorization is effective immediately and shall remain in effect until _____

If no date is indicated, this Authorization will expire twelve (12) months after the date of requestor's signature at the bottom of this form.

A copy of this Authorization shall be valid as an original.

_____ _____

Signature of patient or patient's legal representative Date

_____

Printed name of signatory

_____

Relationship to patient (if signed by other than patient)

Print Form

For Mental Health Clinic Use Only

Request noted by MHC Provider: _____(Initials)

MR #: _____ Initials: _____

☐ mailed ☐ faxed ☐ hand carried by pt.

Date Completed: _____

For Medical Record Office Use Only

MR #: _____ Initials: _____

☐ mailed ☐ faxed ☐ hand carried by pt.

Date Completed: _____